HMO Provider Manual

Effective December 1, 2024

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1 | Introduction and Guide to Manual

Welcome

Anthem is committed to working with Providers to meet the needs of Members. This Provider Manual ("Manual") contains important information regarding key administrative requirements, policies and procedures including but not limited to Claims submission, reimbursement and administrative policies and requirements, credentialing, utilization management and quality improvement. This Manual contains many references to additional policies, procedures, forms, and other useful information that can be found on the website at **Anthem.com**. The Agreement with Anthem requires Providers to comply with Anthem policies and procedures including those contained in this Manual. Payment may be denied, in full or part, based upon the Providers failure to comply with the Manual. However, in the event of an inconsistency between the Agreement and this Manual, the Agreement will govern.

This Manual is intended to support all medical groups that have executed a Provider agreement with Anthem. The use of "Provider" within this manual refers to entities contracted with Anthem that submit professional claims.

Capitalized terminology in this Manual is defined in the Anthem Provider Agreement otherwise referred to in this Manual as "Agreement". The provisions of this Manual apply unless otherwise required by the Agreement.

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 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. 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 should consult their advisors for advice on these topics.

Using this manual

This Manual is available to you on our website at **Anthem HMO Provider Manual**. Scroll down to Provider Manual, then select Download the Manual. From the Provider Manuals page, scroll down towards the bottom of the page under Provider Manual Library and select Anthem Blue Cross HMO Provider Manual.

Click on any topic in the Table of Contents, to automatically link to that topic's location. Click on any web address link throughout the manual, to connect to web address sites. Each chapter may contain hyperlinks to important phone numbers, our website or outside websites that provide additional information.

Examples, for illustration purposes only, are included in this Manual. If you have questions about the content of this Manual, contact your Provider Experience Representative or visit the Contact Us page on our Provider website for up-to-date contact information at **Contact Us**.

2 | Legal and Administrative Requirements

Clinical Data Sharing

Anthem requires Providers to submit clinical data when requested. For details on how to submit clinical data, review the administrative policy by visiting **Anthem.com** select **For Providers**, select **Forms and Guides** (under the Provider Resources column). Type **Clinical Data Sharing** in the **Search Anthem.com bar**. In the left margin, under **Narrow your results**, choose **Providers**.

Financial Institution/Merchant Fees

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

Insurance Requirements

All Providers are expected to carry and produce evidence of current industry standard and/or state required insurance coverage; there is no “one size fits all” for Providers. As such, Anthem’s contractual insurance requirements do not include reference to specific limits, such as “General Liability $1M per occurrence/$3M aggregate”. The red flag would be the lack of professional liability/medical malpractice coverage, or expired certificates, or certificates in a name other than the contract holder.

Provider insurance coverage is secondary to indemnification language; a strong indemnification section provides the guidance regarding which party is responsible in the event of damages/injury to one or both parties to the contract, regardless of the insurance coverage.

Open Practice

Provider 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.

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 Digital Guidelines

Anthem expects Providers will utilize digital tools unless otherwise mandated by law or other legal requirements for transactions such as filing claims, verifying eligibility and benefits, etc.

Providers should refer to the guidance included throughout the Provider Manual where digital tools are available. For a complete list of digital tools, refer to the Provider Digital Engagement Supplement located on **Anthem.com**.

To access the Provider Digital Engagement Supplement, go to **Anthem.com**, select **For Providers**, select **Forms and Guides** (under the Provider Resources column), if needed **Select or Change a State (CA)** at the top right, type **Provider Digital Engagement Supplement** in the **Search Anthem.com** bar.

Referring to Non-Participating Providers

Anthem's mission is to provide affordable quality healthcare benefits to its Members. Members access their highest level of healthcare benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to non-participating Providers in non-emergent situations or without Anthem's prior approval.

Anthem has established Maximum Allowed Amounts for services rendered by non-participating Providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non- participating Provider, the payment will be remitted to the Member in most situations rather than the non- participating Provider; and Members may be balance-billed by non-participating Providers for the difference between the amount they charge for the service and the amount paid to that non-participating Provider.

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

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements.

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

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

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

Encounter Data for Risk Adjustment Purposes

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

Because HHS requires that health plans submit all ICD10 codes for each beneficiary, Anthem also collects diagnosis data from the Members medical records created and maintained by the medical group and contracted Providers.

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, 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, medical group and contracted Providers 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 medical group Agreement with Anthem, the medical group and contracted Providers 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.

Medical group and contracted Providers 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) 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, medical groups and contracted Providers also may be required to produce certain documentation for Members enrolled in Medicare Advantage or Medicaid.

California Commercial Risk Adjustment Programs

There are two distinct programs that work to improve risk adjustment accuracy and focus on performing appropriate interventions and chart reviews for patients with undocumented Hierarchical Condition Categories (HCC), in order to document and close the coding gaps.

The Prospective Program focuses on patients with ACA plans, regardless of exchange status, which require a comprehensive visit to recapture specific chronic health conditions. Medical Group and contracted Providers are required to:

- Establish the point of contact responsible for working with Anthem's Commercial Risk Adjustment team
- Schedule targeted patients for a comprehensive visit within the calendar year, no later than December 31
- Submit the appropriate encounter file following the patient's visit

The Retrospective Program requires the Medical Group and contracted Providers to fulfill medical record requests for Commercial Risk Adjustment reporting purposes. As stated in the previous section, RISK ADJUSTMENT PURPOSES, the Medical Group and contracted Providers 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. The Retrospective Program begins in May of the reporting year and ends in April of the following year.

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.

For more information on the performance measures and health plans monitoring please see section titled Medical Group Oversight.

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.

Websites

The Anthem website and this Manual may contain links and references to Internet sites owned and maintained by third parties. Neither Anthem nor its related affiliated companies operate or control, in any respect, any information, products or services on third-party sites.

Anthem disclaims all warranties, expressed or implied, including, but not limited to, implied warranties of merchantability and fitness. Anthem does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of correctness, accuracy, timeliness, reliability or otherwise.

Anthem Providers agree to use this Manual solely for the purposes of referencing information regarding the provision of medical services to Anthem HMO Members.

Updates and Changes

This Manual, as part of your Provider Agreement, is subject to change at any time.

In the event of a material change to the Manual, we will make all reasonable efforts to notify you, in writing, in advance of such change. In such cases, the most recently published information should supersede all previous information and be considered the current directive. The Manual is not a complete statement of all Anthem policies or procedures. Additional policies and procedures are located on Anthem's website or published in written communications. This Manual does not contain legal, tax or medical advice. Consult with your own advisors for such advice.

3 | Quick References

This section of the manual includes HMO References

Service Departments	Contact Information
American Specialty Health (ASH)	☎ **(800) 678-9133**
Ancillary – CA Enterprise Ancillary Contract Support: Ambulance, Audiology, Cardiac Event Monitoring, Dialysis, DME, Hearing Aid Dispensers, Home Health, Home Infusion, Hospice, Lab, Outpatient Therapy (PT/OT/ST), Skilled Nursing Facilities	Email Address: **EnterpriseAncillary@Anthem.com**
Anthem Blue Cross Website	Link: **Anthem.com**
Anthem HMO Clinical Ops Utilization Management (UM) Department	☎ **(866) 757-8211** ☎ **(866) 461-2401 (Fax)**
Anthem Point of Service (POS), Blue Cross Plus	☎ **(800) 288-6921** P.O. Box 4239 Woodland Hills, CA 91365-4239
Availity Essentials Client Services: Obtain eligibility, benefits, claim status, secure messaging and authorizations through Interactive Care Reviewer	Website Address: **Availity.com** Availity Essentials Client Services: ☎ **(800) AVAILITY (1-800-282-4548)** Monday – Friday, 5:00 a.m. to 5:00 p.m. PT
Away from Home Care	Email Address: **afhc.help@bcbsa.com** Away from Home Care Blue Cross Blue Shield Association 225 North Michigan Avenue, 4th Floor Chicago, IL 60601-7680
CA Behavioral Health (BH) Network Relations: Support for participating BH and Applied Behavior Analysis (ABA) Providers (individuals and groups)	Information about joining the CA Behavioral Health Network Website Address Link: **Behavioral Health Network Participation Application** To check the status of your request: Email Address: **CABHContracting@Anthem.com**
Care Management/Utilization Review (includes Behavioral Health)	☎ **1 (800) 274-7767** Anthem Review Center Pre-Service Hospital Admissions P.O. Box 4137 Woodland Hills, CA 91365-4137

Service Departments	Contact Information
CA Contract Support – (Provider Experience) Support for Participating Medical Groups	**Contact Us**
California Department of Managed Healthcare – The California Department of Managed Healthcare (DMHC) is responsible for regulating healthcare service plans. For more information on grievance procedures, see the Grievance and Appeals Process section in this manual	Department of Managed Healthcare (DMHC) Help Center 980 9th Street, Suite 500 Sacramento, CA 95814-2725 DMHC Help Center 1 (888) 466-2219 DMHC Internal TDD line: **☎ 1 (877) 688-9891 (TDD)** DMHC's website (online complaint forms and instructions): **ww.dmhc.ca.gov** Health Plans and Providers: **☎ (916) 324-8176** **☎ (916) 255-5241 (Fax)** Health Plans Division California Relay Service: **☎ (800) 735-2929 (TTY)**
California Hospital Association (CHA)	**☎ (916) 443-7401** Advanced Healthcare Directive Forms Website: **www.calhospital.org**
California Medical Association (CMA)	**☎ (800) 882-1262** Advanced Healthcare Directive Kit (includes form) **www.cmadocs.org**
CalPERS Customer Service	**☎ 1 (877) 737-7776**
Case Management/Disease Management Commercial HMO Anthem Blue Cross	Referrals: **☎ 1 (888) 613-1130** **☎ 1 (800) 947-4074 (Fax)** Attn: Case Management P.O. Box 4307 Woodland Hills, CA 91365-4037
Claims & Correspondence:	Claims and correspondence should be sent via Federal Express, registered or certified mail to: Anthem Blue Cross/Name of Product c/o Exela Technologies P.O. Box 60007 Los Angeles, CA 90060-0007
EDI (Electronic Data Interchange): Electronic submission for claims and Encounter Data	Contact Availity Essentials Client Services at: **☎ 1 (800) AVAILITY (1-800-282-4548)** Monday – Friday, 5:00 a.m. – 5:00 p.m. PT Link: **Availity.com**

Service Departments	Contact Information
Electronic Funds Transfer (EFT) Registration	To register or manage Electronic Funds Transfer (EFT): Go to **Anthem.com,** select **For Providers** from the top horizontal menu then select **Electronic Data Interchange (EDI)** under Claims. Next, scroll down to, **Select Your State**, once on the EDI page scroll to the bottom section **EDI Resources** and select the **Electronic Funds Transfer** tab.
Transgender Service Requests (for CA Local Commercial Plans)	☎ **1 (855) 484-4930** ☎ **1 (866) 461-2401 (Fax)**
Transplant and Specialty Services Department	☎ **1 (888) 574-7215** ☎ **1 (866) 255-2471 (Fax)** 13550 Triton Park Blvd. Mailpoint: KY0304-A670 Louisville, KY 40223
Finance	Anthem Blue Cross Attn: HMO Finance – Oversight 21215 Burbank Blvd Mailstop: CA9304-L04E Woodland Hills, CA 91367
Financial Operations: Overpayment recovery	Large Group, Individual & Small Group Plans: ☎ **1 (818) 234-3289**
Grievance and Appeals: Formal dispute process for a processed claim or disagreement with the final determination of a claim or clinical review. **Note: For Behavioral Health Grievance and Appeals Department, refer to the CA Behavioral Health Section Above** Grievance and Appeals Phone Numbers	Grievance and Appeals Department P.O. Box 60007 Los Angeles, CA 90060-0007 Provider Dispute Resolution (PDR) Form on Anthem.com **Provider Dispute Resolution Request Form** PDR Form on **Availity.com** Anthem Blue Cross Grievance and Appeals Department P.O. Box 4310 Woodland Hills, CA 91365-4310 ☎ **1 (800) 365-0609** ☎ **1 (866) 333-4823 TDD)** ☎ **1 (877) 551-6183 (Fax)** **Expedited Appeals:** ☎ **1 (855) 211-3699 (Fax)**
Health Insurance Marketplace (Exchanges)	Eligibility, Benefits & Claims: Provider: ☎ **1 (855) 854-1438** Member: ☎ **1 (855) 453-7031** Contract Support Inquiries: **Contact Us**

Service Departments	Contact Information
Language Assistance Program	Translation of materials: • In person interpretations • Telephone interpretations *Members:* ☎ **1 (888) 254-2721** or the phone number on the back of their ID card *Providers* (For office, or on Members behalf): ☎ **1 (800) 677- 6669** Request to speak with an interpreter Interpretation: Instruct Members to call the phone number on the back of their ID card
Pharmacy Program	Prescription Drug Prior Authorization Requests (PAB): ☎ **1 (844) 474-3347 (Fax)** – Commercial ☎ **1 (844) 474-6219 (Fax)** – On Exchange ☎ **1 (888) 223-0550 (Fax)** – Specialty Pharmacy Prior Authorization Request follow-up (after 45 days): ☎ **1 (833) 293-0659** To obtain a list of PAB medications or formularies: Prescription Drug Plan Customer Service Center ☎ **1 (800) 700-2541** Medical Specialty Pharmacy Support (CVS Specialty Pharmacy): Prescriptions Only. Prescription specialty medication can be ordered for delivery at: ☎ **1 (877) 254-0015** ☎ **1 (866) 336-8479 (Fax)** Monday – Friday, 4:30 a.m. – 7:30 p.m. PT Saturday, 6:00 a.m. – 10:00 a.m. PT
Provider Care: Customer Service for Providers Eligibility, benefit & claims questions, Grievance and Appeal Inquiries	Refer to the Customer Service number on the back of the Member ID Card
Provider Data Solutions: Facilitates the data maintenance of Provider information for medical groups, facility Providers, physicians & ancillary network Providers, California Behavioral Health Network Providers and professional Providers	Anthem uses the Provider Data Management (PDM) application on Availity Essentials* to verify and initiate care provider demographic change requests for all professional and facility care providers. Availity Essentials* Provider Data Management (PDM) is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads. Availity PDM replaced all other intake channels for demographic change requests and roster submissions. Website Address: **Availity.com**

Service Departments	Contact Information
Provider Services: Questions on participation status, report misrouted PHI	☎ **1 (800) 677-6669**
Transition Assistance & Second Opinion: Review of Continuity of Care (COC)/Transition of Care (TOC) requests for eligible new enrollees and those affected by network disruption. Review of Second Opinion requests to Providers outside HMO Members medical group	To initiate requests, call the customer service number on the back of the Members ID card. Medical COC/TOC & Second Opinions: ☎ **1 (888) 486-4227** ☎ **1 (877) 376-0430 Second Opinion (Fax)** ☎ **1 (877) 214-1781 Transition Assistance (Fax)** Applied Behavior Analysis (ABA) COC/TOC: ☎ **1 (844) 269-0538** ☎ **1 (866) 582-2287 (Fax)** Behavioral Health COC/TOC: ☎ **1 (800) 274-7767** ☎ **1 (877) 521-4787 (Fax)**
Workers' Compensation	Email Address: **AWCCustomerRelations@Anthem.com** Customer Relations (Medical Provider Network): ☎ **1 (866) 700-2168** Customer Relations (Claims): ☎ **1 (855) 766-3719** Claims for Workers' Compensation: Anthem Blue Cross Workers' Compensation P.O. Box 70022 Anaheim, CA 92825-0022 WCMCS Website: Link**:** **WCMCS Website** California Division of Workers' Compensation: **California Division of Workers' Compensation**

Definitions

This list of definitions is in addition to those provided in the Definitions Section of your Provider Agreement.

There are many terms used throughout the Provider Manual that describe various products, contracted Providers, organizations and specialized services that relate to managed care. The following definitions will help you understand this terminology.

Accidental Injury
Physical harm or disability that is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

Accreditation
An evaluative process in which a healthcare organization examines its operating procedures to determine whether they meet designated criteria as defined by the accrediting body and ensures that the organization meets a specified level of quality.

Acupuncturist
A doctor of acupuncture (Lac) who is a licensed by the State and qualified to perform acupuncture services.

Acute Rehabilitation
Therapy to restore a Members disability to self-sufficiency or functional independence. An inpatient rehabilitation program utilizes an inter-disciplinary coordinated team approach that involves a minimum of three (3) hours rehabilitation services daily. These services may include physical therapy, occupational therapy, speech therapy, cognitive therapy, respiratory therapy, psychology services, or prosthetic/orthotic services or a combination thereof.

Ambulatory Surgical Center (ASC)
An ambulatory surgical center is a freestanding outpatient facility licensed according to State and local laws, which meets all requirements to provide surgical services. It must also meet the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Accreditation Association of Ambulatory.

Healthcare (AAAHC). Anthem meets National Committee for Quality Assurance (NCQA) requirements in credentialing ASCs.

Anthem
A Health Insurance Plan Provider, regulated by the California Department of Managed Healthcare (DMHC). The Health Plan may be referred to as “we”, “our” or “us”, Anthem Blue Cross, Blue Cross or Anthem.

Anthem Life and Health Insurance Company (Anthem Life and Health)
An Anthem affiliate insurance plan Provider.

Anthem HMO Participating Provider
A physician, facility or medical group that has entered into an Agreement with Anthem to provide medical services to Anthem HMO plan Members.

Applied Behavior Analysis
An applied science that develops methods of changing behavior and a profession that provides services to meet diverse behavioral needs.

Appeal
An oral or written request to change an initial determination made by the medical group or Anthem.

Authorization
The medical group's or Anthem's approval of a referral made by the Members primary care physician (PCP) or medical group.

Approved Screening Criteria
The written and/or online clinical guidelines and medical policies used to screen healthcare services for medical appropriateness. Inpatient guidelines include severity of illness, intensity of service and length of stay, which are reviewed and approved by Anthem's oversight committees. Oversight committees primarily include practicing physicians. Criteria and guidelines are national in scope; developed with actively practicing physicians, hospitals, facilities or other healthcare professionals; and are reviewed and updated at least annually.

Away-From-Home Care
Urgent care, away-from-home emergency care, routine care and follow-up care as defined in the Away From Home Care Member Evidence of Coverage (EOC) or Benefit Agreement. Away From Home Care (AFHC) allows Members who are enrolled in eligible products to receive similar coverage while living out of state for at least 90 consecutive days. AFHC is available for Large Small group Members in California. This benefit is not available for Individual Plan Members. The Anthem state where the Member is covered is the home state; the state where they are living temporarily is the host state. AFHC is also known as a Guest Membership. It applies to the following types of Members while they are living out of their home state:

- Students, including dependents attending school in another state and not living with the subscriber
- Families apart, including divorce situations or separated families where the spouse or dependent is not residing with the subscriber; this is available for spouses and dependents
- Long-term travelers, including long-term work assignments or retirees with dual residence; this is available for subscribers, spouses or dependents

Anthem Blue Cross
The trade name of Blue Cross of California, a corporation that offers healthcare service plans and is regulated by the California Department of Managed Healthcare (DMHC).

Anthem Blue Cross HMO
An HMO plan offered by Anthem.

Anthem HMO Case Manager
An Anthem associate responsible to assist medical groups with case management.

Anthem HMO Hospital
A hospital that has a Provider Agreement with Anthem to provide hospital services to HMO Members.

Anthem HMO Quality Management Representative
An associate of Anthem who is responsible for Anthem HMO Quality Management programs.

Anthem Managed Care Network
The network of physicians, hospitals, facilities, and other healthcare professionals that have contracts with Anthem and one or more of its affiliates. Under these contracts, the physicians, hospitals, facilities, and other healthcare professionals agree to participate in the Anthem HMO product and administer it according to the terms of the Members EOC.

Anthem Medical Policy

- **Medical Policy & Technology Assessment Committee**. 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.
- **Anthem Office of Medical Policy & Technology Assessment**. The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and Clinical Utilization Management (UM) Guidelines (collectively "Medical Policy") for Anthem.

Availity
Provides single sign-on, secure, multi-payer access to eligibility and benefits inquiry, claim status inquiry, claim submission, pre-authorizations and more. Availity Essentials is a leading health information network, providing business and clinical services and resources. This secure, multi-payer portal is available at no charge to physicians and other healthcare Providers. Availity Essentials improves efficiencies through simplified and streamlined Health Plan administration.

Benefit Agreement (also known as Evidence of Coverage or EOC)
The written agreement between Anthem and a group or individual, pursuant to which Anthem indemnifies healthcare expenses, provides or administers healthcare benefits, or otherwise pays or arranges for the payment of benefits for healthcare services.

Benefit Denial
The denial of healthcare services by Anthem, or a contracted medical group, based on service that is excluded as a covered benefit under the terms and conditions of the Members EOC.

Behavioral Health Conditions
Conditions that affect thinking, perception, mood and behavior. A mental or nervous disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived (e.g., seeing or hearing things that are not there), sudden and/or extreme changes in mood (e.g., depression), and/or unusual behavior, such as marked withdrawal or highly agitated or manic behavior.

Any condition meeting this definition is a mental or nervous disorder, no matter what the cause of the condition may be; but medical conditions that are caused by Member behaviors that may be associated with these mental conditions (e.g., self-inflicted injuries and treatment for severe mental disorders) are not subject to the below limitations. Any of these conditions may be exclusions under a Members EOC.

Anthem pays for the following Covered Services provided under the Members EOC: The same inpatient services as those provided for any other condition, subject to any limitations applicable to the treatment of mental disorders.

Any additional inpatient services needed for detoxification during acute withdrawal from alcohol or other drugs.

Covered Services under the applicable Benefit Agreement include psychological testing, psychological consultations, psychiatric consultations and group therapy. Care can be administered by psychiatrists, licensed psychologists, marriage and family therapists, or licensed clinical social workers. Covered outpatient mental health services are not limited to acute intervention.

In some cases, a psychiatric condition can have secondary medical conditions associated with it. In these cases, the Medical Review Department reviews the claim and assigns the provision of medical services for treatment of the psychiatric condition for mental health benefits.

Medically necessary marriage, family, or group counseling is subject to the terms of the applicable Member EOC. Each Member attending a session is responsible for their own copayment, and each session counts as a visit toward that Members visit maximum.

Business Day
Monday through Friday, excluding designated Company holidays.

Centers of Medical Excellence (CME) Network
The healthcare network that has contracts with Anthem and/or one or more of its affiliates, pursuant to which those Providers have agreed to participate in a transplant program or other designated specialty program.

Child
The subscriber, spouse or domestic partner's natural child, stepchild or legally adopted child. This may include court-appointed legal guardians of a child.

Chiropractor
A Doctor of Chiropractic (DC) licensed by the State who is qualified to perform chiropractic services.

Clean Claim
A claim that has no defect or inaccuracy. Clean claims include substantiating documentation needed to meet the requirements for risk adjustment submission.

Coinsurance
A percentage of the total amount for a healthcare service that a Member is required to pay for services.

Complicated Pregnancy
A tubal pregnancy, cesarean section, eclampsia or other condition directly caused by pregnancy and considered a distinct complication of pregnancy. This does not include elective abortions, false labor, occasional spotting, morning sickness or physician-prescribed rest.

Contracting HMO Hospital
A hospital who has signed and agreed to an Anthem Facility Agreement. The hospital must be Medicare certified.

Coordination of Benefits (COB)
The method of determining primary responsibility for payment of covered services, under the applicable Benefit Agreement terms or insurance policy, and applicable law and regulations, when more than one payor may have liability for payment of services received by an Anthem Member.

Copayment
A fixed amount that is payable on a per-service basis. For HMO plans, the payment amount indicated in the Anthem HMO Benefit Information Report is due and payable by the Member to the medical group, hospital or other healthcare Provider.

Copayments are due at the time of service. If the collection of a copayment is not possible at the time of service, the Member should be billed. See the Anthem HMO Benefit Information Report for maximum out-of-pocket (MOOP) liability. For more information about this report, refer to the **General Benefits** section.

Cosmetic and Reconstructive Surgery
Procedures are considered cosmetic when they are intended to change a physical appearance that are considered within normal human anatomic variation.

Procedures are considered reconstructive when they are intended to address a significant variation from normal related to accidental injury, disease, trauma, and treatment of a disease or congenital defect.

Note: Not all benefit contracts include benefits for reconstructive services as defined here. Benefit language supersedes medical policy.

Covered Expense
The expense incurred by a Member for covered services, but not more than the customary and reasonable charge, or any lesser ceiling than Anthem's allowance as outlined in the Members EOC.

Custodial Care
Custodial care generally provides assistance in performing activities of daily living (ADL), (e.g., assistance walking, transferring in and out of bed, bathing, dressing, using the toilet, and preparation of food, feeding and supervision of medication that usually can be self-administered). Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel.

Deductible
The amount Members must pay for covered services, before benefits under the Members plan begin. The Member's deductible is referenced in their EOC. Deductibles are not applicable to all plans.

Direct Access
This program allows Members to self-refer to certain specialties within the medical group listed in your Provider Agreement. The Member does not need to obtain a referral from a PCP and no other type of prior authorization from the Members assigned medical group is required to visit the specialist. See the **General Benefits** section for further information.

Disenrollment
The process of ending the Members Membership in Anthem plans. In such a case, Anthem does not have any further responsibility to provide care, funding or reimbursement for care.

Durable Medical Equipment (DME)
Equipment must meet the following criteria:

- It can withstand repeated use.
- It is used to serve a medical purpose.
- It is generally not useful to a person in the absence of illness or injury.
- It is appropriate for home use.

To be covered, DME must be medically necessary and prescribed by a contracting physician for home use. DME includes oxygen equipment, wheelchairs, hospital beds, and other items that Anthem determines to be medically necessary.

Effective Date
The date the Members coverage begins under their plan.

Eligibility Guarantee
Eligibility guarantee ensures reimbursement, to the extent required by California law, to the medical group when services are performed in good faith, and the Member is later found to have been ineligible at the time of service. Check your Provider Agreement for verification and details.

Emergency Services
Emergency services means covered inpatient and outpatient services that are:

- Furnished by a Provider qualified to furnish emergency services; and
- Needed to evaluate or stabilize an emergency medical condition.
- Members are not required to go to health-plan affiliated hospitals and practitioners when they experience an emergency.

Out-of-Area Emergency services are services that are received outside of the service area defined the medical group's Provider Agreement. For a more extensive definition of "emergency service area," refer to the **General Benefits** section.

Encounter
An itemized statement of services, similar to a claim, which is submitted to Anthem indicating a patient's visit or treatment with a medical physician, hospital, facility or other healthcare professional. Encounter data is submitted to provide a summary of rendered medical services.

Enrollment Area
The geographical area within the service area outlined in the medical group's Provider Agreement. Anthem encourages the Member to select a PCP within the service area outlined in the Members EOC.

Evidence of Coverage (EOC)
Please see Benefit Agreement definition.

Expedited Appeal
Review of healthcare services, which in the opinion of the treating healthcare Provider, any healthcare Provider with knowledge of the covered person's medical condition, or a prudent layperson's judgment, which in the absence of expedited review timeframes could:

- Cause potential loss of life, limb or major bodily function
- Subject the Member to severe unmanageable pain, without the treatment that is the subject of the appeal.

If you submit an expedited appeal, we will respond with our decision about the Members requested medical care within 72 hours after you or the Member ask for it – sooner if the Members health requires a quicker turnaround timeframe.

Family Member
The subscriber's enrolled spouse, domestic partner and/or each enrolled eligible child.

Federal Employees Health Benefits (FEHB)
Employer-sponsored group HMO health insurance program covering Federal employees, retirees, former employees, family members, and former spouses.

Follow-Up Care
Care after an initial medical emergency service.

Full-Time Employee
An employee who meets the eligibility requirements for full-time employees as outlined in the Benefit Agreement.

Grace Period
A defined time between the group's bill due date and the date Anthem will cancel coverage, if payment is not received. Refer to "Grace Period Status" for specific guidelines for Individual Plan Members.

Grievance
An oral or written expression of dissatisfaction with the Plan, a medical group, physician, hospital, facility or other healthcare professional.

Home Health Agency and Visiting Nurse Association
Home Healthcare facilities licensed according to State and local laws to provide skilled nursing and other services on a visiting basis in the Members home. The agency must be an approved Home Healthcare facility under Medicare and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Hospital
A facility that provides diagnosis, treatment and care of persons who need acute inpatient hospital care under the supervision of physicians.

- The hospital must be licensed as a general acute care hospital according to State and local laws.
- The hospital must be registered as a general hospital by the American Hospital Association, meet accreditation standards of the JCAHO and be Medicare certified.
- For the limited purpose of inpatient care for the acute phase of a mental or nervous disorder, the term "hospital" also includes psychiatric health facilities.

In-Network Services
In-Network services are those services that are received within the service area outlined in the medical group's Provider Agreement.

Infertility
The presence of a demonstrated condition recognized by a licensed physician as a cause of infertility, or the inability to conceive or carry a pregnancy to a live birth after a year or more of regular sexual relations or after three cycles of artificial insemination without contraception.

Initial Request/Continued Stay Review (Continuation of Services)
Review for medical necessity during initial/ongoing inpatient stay in a facility (hospital), or a course of treatment, including review for transition of care and discharge planning.

Investigational Criteria (Medical Policy)
"Investigational" means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet Company Technology Evaluation Criteria because it does not meet one or more of the criteria.

Additional information can be found under medical policy **ADMIN.00005**.
Click on this link: **Investigational Criteria Medical Policy**.
These criteria are used in the development of and updates to medical policies. Benefit determinations are to be made based on the definition of investigational, within the Members EOC.

Involuntary Member Transfer
Consists of the Members reassignment to a medical group other than the one chosen by the Member, with or without the Members consent.

Life Threatening
Means either or both of the following:

- Diseases or conditions where the likelihood of death is high, unless the course of the disease is interrupted
- Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival

Managed Care Network
The network of healthcare professionals who are contracted with Anthem and/or one or more of its affiliates pursuant to which those healthcare professionals have agreed to participate in Anthem programs that are to be conducted pursuant to Benefit Agreements.

Maximum Out of Pocket (MOOP) Liability
The most the Member will pay in deductibles, copayments, and/or coinsurance during a benefit period for covered services. Also referred to as Out-of-Pocket Maximum.

Medical Group
A group of physicians, organized as a legal entity, which has a Provider Agreement in effect with Anthem to furnish medical care to Members.

Medical Necessity Denial
A healthcare service that is denied by Anthem or a contracted medical group, in whole or in part, based on a finding that a service is not medically necessary.

Medical Services
Those services provided by a participating physician, hospital, other facility, or other healthcare professional and covered by a Benefit Agreement.

Medicare Allowed Amount
A charge limit determined by CMS and administered in accordance with Medicare guidelines, as confirmed by Anthem.

Mental Health and Substance Use Disorder
A Mental Health Condition or Substance Use Disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Changes in terminology, organization, or classification of Mental Health and Substance Use Disorders in future versions of the *American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders* or the *World Health Organization's International Statistical Classification of Diseases and Related Health Problems* shall not affect the conditions covered by this Plan as long as a condition is commonly understood to be a Mental Health Condition or Substance Use Disorder by health care Providers practicing in relevant clinical specialties.

National Committee for Quality Assurance (NCQA)
An independent, non-profit organization that accredits managed healthcare plans, by measuring the quality of care and service provided by managed care plans such as HMOs. Its standards help ensure HMO customers receive high-quality healthcare and excellent service. The organization also encourages health plans to create an environment for continuous improvement.

NPI (National Provider Identifier)
A 10-digit identification number issued by CMS to healthcare Providers. Currently required for select electronic healthcare transactions, per HIPAA legislation.

Newborn
A baby less than 31 days old.

Non-Clean Claims
A claim that has a defect or inaccuracy. A non-clean claim lacks substantiating documentation that is required to make timely payment.

Non-Participating Physician or Other Healthcare Professional
A licensed physician or other healthcare professional who does not have a Provider Agreement with Anthem or a medical group.

Notification
The telephonic and/or written/electronic communication to the applicable healthcare Providers, facility and the Member documenting the decision (Utilization Management review outcome - approval, denial, pend for additional information, etc.), and informing the healthcare Providers, facility and Member of their rights if they disagree with the decision.

Office Visits or Consultations
Office visits or consultations with a Member physician or any referral physician for basic medical care. Medically necessary services or supplies used in the PCP’s office and/or consulting physician’s office are covered, for as many visits per day as are medically necessary.

Open Enrollment
Open enrollment is a window of time, usually determined by an employer or State/Federal mandate, during which individuals and employees may add, make changes to, or cancel their health insurance coverage.

Out-of-Network Services
Services that are rendered by a non-participating physician or other healthcare professional, except for approved out-of-area emergency and urgent care services.

Outpatient Prescription Drug Expenses
The benefit amount paid by Anthem for a Members covered outpatient prescription expenses.

Participating Hospital
A hospital that has a Provider Agreement to provide hospital services as a participating facility.

Patient Stabilization
A patient is considered stable when the treating physician or other licensed Provider determines the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from or occur during the release or transfer of the patient.

Physician
A Doctor of Medicine (MD) or a doctor of Osteopathy (DO) who is licensed by the State, to provide MD or DO services.

Pre-Service Review
Medical necessity review that is done prior to authorizing healthcare services or supplies to a Member.

Primary Care Physician (PCP)
A PCP is responsible for authorizing, coordinating and overseeing the delivery of covered services to Members. PCPs include General and Family practitioners, Internists, Pediatricians and other specialists that Anthem may designate as PCPs.

Probation
Consists of written notification detailing the cause of action and notifying the Member that any repetition of the cause of action will result in immediate disenrollment.

Progressive Notification
A series of three notification letters sent to a Member detailing the cause of action and requesting that the Member work with the medical group and/or Anthem to remedy the issue within a specific timeframe. The Member is advised that failure to do so may jeopardize their Anthem coverage.

- If a Member fails to correct the issue/behavior within the timeframe specified by the first letter, a second notification letter is sent to the Member.
- If the Member has not remedied the issue after the second letter, the case is reviewed by the Grievance and Appeals Committee and Anthem Corporate Counsel prior to sending a third notification letter.

Prosthetic Devices
Appliances that replace all or part of the function of a permanently inoperative, absent or malfunctioning body part. The term "prosthetic devices" includes orthotic devices and rigid or semi-supportive devices that restrict or eliminate motion of a weak or diseased part of the body.

Provider
Any individual or entity that is engaged in the delivery of services to Anthem HMO Members, or the ordering or referring for those services, and is legally authorized to do so by Anthem or delegated entities on our behalf.

Psychiatric Health Facility
An acute 24-hour facility as defined in California Health and Safety Code Section 1250.2. It must be:

- Licensed by the California Department of Mental Health.
- Qualified to provide short-term inpatient treatment according to state law.
- Accredited by the Joint Commission on Accreditation of Healthcare Organizations.
- Staffed by an organized medical or professional staff that includes a physician as its Medical Director.

Psychiatric Mental Health Nurse
A registered nurse (RN) with a master's degree in psychiatric mental health nursing, who is registered with the California Board of Registered Nursing as a psychiatric mental health nurse.

ReadyAccess
An umbrella term for the programs that offer expedited referrals – Speedy Referral and Direct Access.

Referral
Any request for authorization by the PCP to the medical group for Covered services or hospitalization. These services may require medical necessity review by the medical group or Anthem.

Related Hospital Services
Services rendered to Members as part of, and concurrent with inpatient hospital, outpatient hospital, hemodialysis, skilled nursing facility, alternative birthing center and hospice services. These services include the use of facility equipment, radiopharmaceuticals, surgical and anesthetic supplies, oxygen, drugs (except for take-home drugs), blood and blood processing, laboratory procedures, and diagnostic imaging and testing.

Residential Treatment Center
An inpatient treatment facility where the patient resides in a modified community environment and follows a comprehensive medical treatment regimen for treatment and rehabilitation as the result of a mental or nervous disorder. The facility must be licensed to provide psychiatric treatment of mental or nervous disorders, according to State and local laws.

Skilled Nursing Facility (SNF)
An institution that provides continuous skilled nursing services. The institution must be licensed according to State and local laws and be recognized as a SNF under Medicare. For the purpose of care provided for the treatment of mental or nervous disorders, a residential treatment center is considered a SNF.

Special Care Units
Special areas of a hospital that have highly skilled personnel and special equipment for acute conditions requiring constant treatment and observation.

Specialist
A physician who has specialized training in a particular medical field. Examples are Cardiologists, Dermatologists and Neurologists.

Specialty Pharmaceutical (Specialty Medications)
Specialty pharmaceuticals are best identified by product characteristics. If they have some or all of the following characteristics, they may be defined as “specialty,” thereby requiring distinct distribution processes, networks and utilization management efforts:

- Produced by recombinant DNA technology or other biological process
- Can be administered as an injection, infusion or even orally
- Targeted diseases have little or no alternative treatments
- Setting for the administration can be the home, physician’s office, outpatient clinic or another outpatient setting
- Typically target underlying disease pathology, versus merely relieving symptoms
- Higher cost per prescription than conventional therapies
- Drug toxicities and disease pathology combined to demand customized clinical monitoring and patient support
- May require temperature control or other specialty handling techniques

Speedy Referral
A program in which PCPs are empowered by the medical group to refer Members directly to participating specialists.

Spouse
The subscriber’s spouse under a legally valid marriage.

Totally Disabled Family Member
A subscriber’s eligible family Member who is unable to perform all usual activities for a person of their age.

Totally Disabled Subscriber
A subscriber who, because of illness or injury, is unable to work for income in any job for which they are qualified, or for which they become qualified by training or experience, and who is unemployed.

Urgent Services
Urgently needed services are covered services (non-emergent), provided when an enrollee is temporarily absent from the Health Plan’s service area or continuation area. In unusual and extraordinary circumstances, are provided when the enrollee is in the service or continuation area, but the Organization’s Provider network is temporarily unavailable or inaccessible), when such services are medically necessary and are immediately required.

Utilization Review
A function performed to review and determine whether medical services are medically necessary.

Utilization Review Reference Number
The tracking number provided to a physician, hospital, facility or other healthcare professional following creation of a Utilization Review case.

Well Woman Care
One visit to an OB/GYN per year for a routine gynecological examination. Members can self-refer to a participating OB/GYN for obstetrical and gynecological care within their medical group’s network.

Workers' Compensation
A State mandated system whereby an employer must pay or provide insurance to pay lost wages and medical expenses of an employee who is injured on the job.

Working Day
Monday through Friday, excluding legal holidays, also known as "business day".

Availity Essentials and Product Summary

Availity Essentials is available to all of our 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.
- **Standard responses:** Responses from multiple payers returned in the same format and screen layout, providing users with a 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 hours a day 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 when applicable 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 in 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-centric educational materials.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Patient360:** A robust picture of a Members health and treatment history, including gaps in care and care reminders.
- **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 Enrollment:** Submit an online request to join Anthem's Provider network.
- **Provider Online Reporting:** access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Remittance Inquiry:** View an imaged copy of the paper Anthem remits up to twenty-four (24) months in the past.

Getting Started and Availity Essentials Training
To register for access to Availity, go to **Register for Access**. For additional assistance with registration, contact Availity Essentials Client Services at the phone number provided in *Section 2, Quick References*, under *Availity Essentials Client Services*. *Click on this link:* **Contact Information**
After logging into Availity, Providers and Facilities have access to many resources to help jumpstart learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources. Availity Essentials also offers onboarding modules for new Administrators and Users.

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 Essentials information.

Organization Maintenance
To update Administrator or Organization information:

- To replace the Administrator currently on record with Availity Essentials call Availity Essentials Client Services at the phone number provided in *Section 2, Quick References*, under *Availity Essentials Client Services*. *Click on this link:* **Contact Information**
- 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. Any changes made to this information automatically applies to all Users associated with the organization and affects only the registration information on Availity.com.

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

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

4 | Eligibility

Verifying Eligibility

Anthem Blue Cross (Anthem) Providers are responsible for verifying eligibility within two (2) business days prior to an authorized, scheduled date of service.

Anthem, on a monthly basis, provides each medical group with an Eligibility Report of all its assigned Members, in addition to providing current real time eligibility information via the Availity Essentials (Availity), 270/271 EDI Transactions, or by calling the Provider Care Department.

Eligibility Guarantee Billing Procedures

Providers are eligible for reimbursement under the Eligibility Guarantee Program if they provide or arrange for healthcare services for a Member whose eligibility was verified as of the date of service, then later determines the Member to be ineligible for that specific date of service. The medical group may seek reimbursement for services by submitting the Eligibility Guarantee Claim Form to the address listed on the form. *Link:* **Eligibility Guarantee Claim Form**. Filter **Category** by **Eligibility** scroll down to **Eligibility Guarantee Claim Form**.

Enrollment

Applicants must complete an Anthem enrollment form, or a form provided by their employer, approved by Anthem. Some larger Member employer groups may submit enrollment electronically.

Members who are new enrollees, may provide a copy of the enrollment form as proof of eligibility, until they receive an ID Card. Providers should make a copy of the enrollment form. Providers should also have the Member complete an Eligibility Certification Form (see link below). If you are unable to confirm a new enrollee's eligibility using Availity, or our Interactive Voice Response (IVR) System, you should follow up with our Provider Care Department the next business day. *Link:* **Eligibility Certification Form**. Type **Eligibility Certification Form** in the **Search Anthem.com** bar. In the left margin, under **Narrow your results**, choose **Providers**.

Effective Dates

The Availity website or Interactive Voice Response (IVR) System are the sources to verify eligibility. Coverage begins at 12:01 a.m. on the effective date. We will notify the Member of the effective date in writing, via an enrollment confirmation letter.

Enrollment in Rural Areas

We recognize many rural areas may have limited access to local care Providers. Exceptions to guidelines governing enrollment may be approved for specific circumstances.

Eligibility Requirements

Members must meet all eligibility requirements established by Covered California or the employer group and/or Anthem. We may request evidence of eligibility requirements, prior to approving health insurance coverage.

Eligible Dependents

Dependents of the subscriber are eligible for coverage, based on the subscriber's EOC, and may include, but are not limited to, the following:

- Spouse or Common Law Spouse

- Domestic partner
- A parent or stepparent who meets the definition of a qualifying relative under federal law and who lives or resides within the Service Area
- Children under the limiting age, including, but not limited to:
    - Stepchildren
    - Children placed for adoption or legally adopted children/grandchildren (only if subscriber has legal guardianship or the employer has purchased additional eligibility coverage)
    - Dependents with a physical or mental impairment. Permanent disability diagnoses must occur prior to the Member reaching the dependent limiting age.

An Eligibility dependent chart is provided at the end of this section.

Selection of a Provider
Anthem HMO subscribers and enrolled dependents must designate a medical group and Primary Care Physician (PCP), if the medical group is an Independent Practice Association (IPA). The subscriber and enrolled dependent(s) may choose their own medical group and/or PCP, as long as the medical group participates in the network in which the Member is enrolled. The medical groups or PCPs selected by the subscriber and dependent(s) do **not** need to be the same. The subscriber and enrolled dependent(s) may select a medical group or PCP within the service area outlined in the Members EOC. If a Member or any enrolled dependent does not designate a medical group or PCP on their enrollment form, Anthem will choose one for them. Anthem will notify the subscriber and dependent(s) of the assignment via mail. The subscriber may request an assignment change, by contacting the Customer Service Department at the phone number located on the back of their ID card.

Transfer of Members
A Member may select a new medical group or PCP. Members must contact Customer Service to request a change to a new PCP. Anthem accommodates Member requests for PCP changes whenever possible. Our staff will work with the Member to make the new PCP selection, focusing on special needs. Our policy is to ensure continued access to care and continuity of care during the transfer process.

Effective Date
Members will be allowed to change their PCP within the same medical group, effective the first of the following month, unless the subscriber's EOC dictates otherwise.

If a Member requests a transfer out of their assigned medical group, and the request is received prior to, or on the 15th of the month, Anthem will make the change effective the 1st day of the following month.

If the request to transfer to another medical group is received after the 15th of the month, the new assignment will be effective the first day of the 2nd month.

If the request is for a PCP Change, our contract may allow for a "retroactive" transfer. The receiving medical group may have the right to refuse acceptance of the Member until the first day of the second month following the request.

If the Member meets all requirements for reassignment, the request will be effective the 1st day of the following month, even though the change request was received after the 15th of the month.

If the 15th of the month falls on a weekend or holiday, Anthem will allow transfer requests received on the 1st business day after the 15th to become effective the 1st day of the following month.

Members in a Course of Treatment
Transfers from one medical group to another, or PCP transfers initiated outside of the Members open enrollment period, **will not be effective until the 1st day of the 2nd month following the Member's discharge from care**, if at the time of the request for transfer or upon the effective date of transfer the Member is in a course of treatment.

Course of treatment includes:

- Member is inpatient at an acute care facility
- Member is inpatient at a skilled nursing facility
- Member is receiving other acute institutional care
- Member is in her 3rd trimester of pregnancy (defined as when the Member reaches the 27th week of pregnancy)

Anthem does not advise Member change requests while a Member is inpatient in a facility, SNF, other medical institution, or undergoing radiation therapy or chemotherapy. A change in Providers may negatively affect their Coordination of Care. The Coordination of Care Form and Letter templates are provided on our Anthem website at **Anthem.com**. Links are provided below:

Coordination of Care Form

Coordination of Care Cover Letter for Behavioral Health Practitioners

Coordination of Care Cover Letter for Medical Practitioners

Retroactive Member Transfers
A Member can make retroactive changes to their medical group or PCP assignment within the same month, in the following instances:

- The Member calls to request a change within 30 calendar days of the Members effective date and has not received services with their originally assigned medical group or PCP.
- The Member calls to request a change within 30 calendar days due to a household move of over the service area designated in the Provider's Agreement, and the Member has not received services with their originally assigned medical group or PCP.

Transfer Due to Termination of Medical Group, Facility or Provider
We will provide prior written notice to Members of any termination of the Members medical group or PCP as applicable, or when required by State or Federal law. In such an event, the Member may be eligible for continuation of care as defined in the **Provider Responsibilities** section of this Manual. For single physician terminations, the medical group shall be responsible for providing the notice to Anthem and Members, in the following circumstances:

- PCP terminations in medical groups where Members are assigned to a PCP (IPAs); and
- All specialist terminations

Each Commercial Member is allowed at least 60 calendar days to select another medical group or PCP. If a response is not received within the timeframe specified in the notice, Anthem will make a selection for the Member, within the service area outlined in the Provider's Agreement.

Members may select a new medical group or PCP within the service area outlined in the Members EOC. In the event of a PCP termination, Anthem will designate a PCP within the Members assigned medical

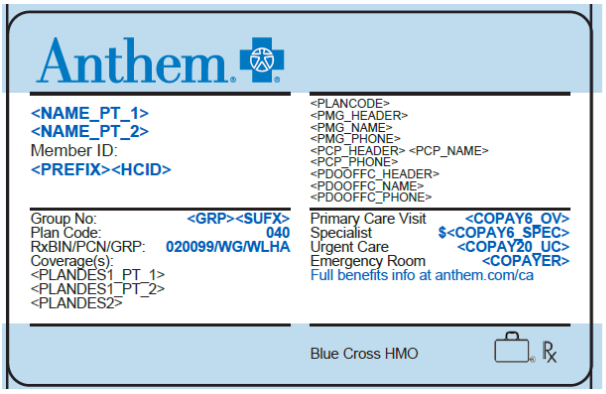
group. The Member will receive a new ID card prior to the first (1st) of the month in which the change is effective.

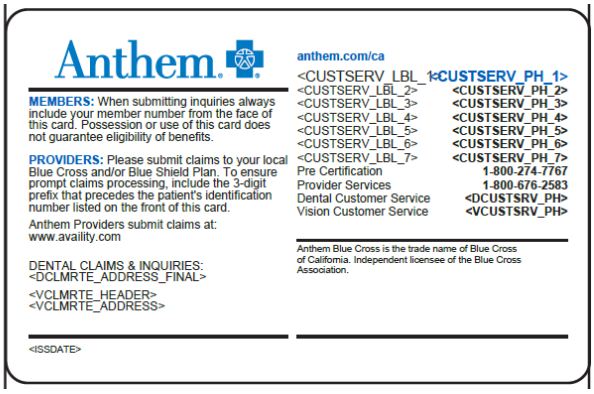
When a Member needs care, and the Members PCP terminated without proper notification, Anthem will reassign the Member to another PCP within the same medical group with an effective date retroactive to the first (1st) of the current month.

Removal of Members
Refer to the **Grievance, Appeals and Disputes** section of this Manual.

Anthem Blue Cross Member ID Cards

Anthem provides Members with an ID card that includes Plan and Provider information on the front and back of the ID card (see sample below):





Eligibility Dependent Chart

Dependent	Category	Definition and Explanation
Spouse	Married	A person who is legally married to the policyholder.
	Common Law	A person with whom you have established a common law union in a State that recognizes common law marriage.
Domestic Partner		**"Must be registered as a domestic partnership with the State"** A domestic partnership is defined as an ongoing, intimate and committed relationship between two persons of the same or opposite sex, who are not legal spouses. Both partners must be 18 years or older (except as provided by California Family Code 297.1). Neither party may be currently married to another party. Neither may be related to the other by blood closer than would prohibit legal marriage. Domestic partners do not include roommates, friends or other similar relationships. Neither party has a different domestic partner now, nor had a different domestic partner within the last 6 months, unless the previous domestic partnership was terminated by death. Both partners agree to be economically responsible to third parties for their common welfare and financial obligations.

Dependent	Category	Definition and Explanation
Children under the limiting age	Legally Adopted Child	Coverage begins on the first day of physical custody if the subscriber submits an enrollment application to the employer group within 30 calendar days of physical custody of the child, unless the subscriber's EOC dictates otherwise.
	Child with Disability/ Disabled Dependent	Certain disabled dependents, regardless of age, may be covered under a subscriber's EOC, provided: • They cannot engage in self-sustaining employment • They depend on the subscriber for support • The disability occurred prior to the dependent reaching the employer's limiting age
	Stepchildren	The child of the Members spouse for as long as they remain legally married to the child's parent.
	Newborn Dependent	**California Commercial:** Knox-Keene regulations dictate eligible newborns are covered for the first 30 days beginning date of birth. If the newborn is not added as a dependent, the newborn is covered under the subscriber's ID for the first 30 days of life. If the mother of the newborn is a dependent of the subscriber, other than the spouse, domestic partner or common law spouse of the subscriber, coverage for the newborn grandchild is not provided, which includes any services beginning with the delivery of the newborn, unless it is specifically stated in the subscriber's EOC.
	Surrogate* (Newborn Coverage)	Anthem may provide coverage for a surrogate when the surrogate is the subscriber or eligible dependent. Refer to the Anthem EOC. However, the newborn dependent(s) may not have coverage upon birth. Surrogate cases are reviewed on a case-by-case basis and newborn coverage denials may be issued to the facility in advance of the newborn's birth. Contact Anthem's Provider Care Department of all surrogate cases. *Medical or facility services incurred by surrogate mothers who are not Anthem Members are not covered.
	Qualified Medical Child Support Order (QMCSO)	A Member (or person otherwise eligible to enroll in an Anthem plan), may enroll an eligible child upon presentation of relevant documentation. A dependent eligible under a QMCSO does not need to reside within the service area to be eligible.
Parent or Stepparent		A parent or stepparent who meets the definition of a qualifying relative under federal law and who lives or resides within the Service Area.

5 | Provider Responsibilities

Introduction

This section provides an overview of Provider responsibilities and Member rights. Members must be referred to participating physicians, facilities, or other healthcare professionals. Medical groups are obligated to abide by responsibilities outlined in their Provider Agreement, as well as the areas outlined in this Provider Manual.

Anthem's website, **Anthem.com** includes the **Find Care** feature that is a tool used by Members to locate contracted physicians. This tool is also used by Providers to locate contracted facilities, physicians and other healthcare professionals, as well as to verify the accuracy of their practice demographic data.

Anthem Provider Website

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

Anthem designed the Provider public website to make navigation easy and more useful for Providers. The website holds timely and important information to assist Providers when working with Anthem. Go to **Anthem.com** and Select **For Providers** from the horizontal menu, then select **Go To Providers Overview**. On the **Providers Overview** page, select **California** and choose content available.

Providers can also sign-up for email communications to be notified when a newsletter is published. Newsletters are designed to educate Providers and their staff on updates and notification of changes. To sign up go to **Anthem.com**. Select **For Providers**, then scroll to the bottom of the page and select **Go To Providers Overview**. Scroll down to **Stay Up to Date Provider News** and select **Read the Most Recent Provider News**. On the Provider Communications page, select **Subscribe to Email** from the top menu bar.

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

- **Provider Resources**
  - Forms and Guides
  - Policies, Guidelines & Manuals
  - Provider Maintenance
  - Pharmacy
  - Behavioral Health
  - Dental
  - Vaccination Resources
  - Find Care
  - Availity, EMR & Digital Solutions
- **Claims**
  - Claim Submission
  - Electronic Data Interchange (EDI)
  - Prior Authorization
  - Provider Appeals
- **Patient Care**
  - Enhanced Personal Healthcare

    - Medicare Advantage
- **Communications**
    - News
    - Contact Us
- **Join Our Network**
    - Getting Started with Anthem
    - Credentialing
    - Employee Assistance Program (EAP)

Online Provider Directory And Demographic Data Integrity

Providers 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** and select the **Find Care** link

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

- **Search as a Member.** Search by entering the Members ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
- **Search as a Guest**. 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 Members ID card.

Updating Demographic Data with Anthem
It is critical that Members receive accurate and current data related to Provider availability.

Providers and Facilities must notify Anthem of any demographic changes. All requests must be received **30 days prior** to change/update. Any requests received within less than **30 days'** notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

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

- 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

Anthem uses the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers. Availity Essentials* Provider Data Management (PDM) is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads. Availity PDM replaced all other intake channels for demographic change requests and roster submissions.

Submitting Provider demographic data requests and roster submissions through Roster Automation

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

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

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

The resources for this process are listed below and available on our website. Visit [plan].com, then under For Providers, 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 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.

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

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

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

The link is provided in *Section 2, Quick References*, under *Provider Data Solutions*.
Click on this link: **Contact Information**

Consolidated Appropriations Act (CAA) of 2021
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 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.

Provider Responsibilities

Providers are responsible for notifying Anthem when changes occur within the Provider practice. All changes must be approved by Anthem. Providers should reference their Agreement for specific timeframes associated with change notifications. Examples of these changes include, but are not limited to:

- Adding new or removing practitioners to the group
- Change in ownership
- Change in tax identification number
- Making changes to demographic information or adding new locations

- Selling or transferring control to any third party
- Acquiring other medical practice or entity
- Change in accreditation
- Change in affiliation
- Change in licensure or eligibility status, or
- Change in operations, business or corporation

Fraud, Waste and Abuse Detection

Anthem is committed to protecting the integrity of Anthem's healthcare 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 unnecessary 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 ensures that the individual seeking services is the same as the Member listed on the card. It is the first line of defense against possible fraud. Learn more at **Fight Healthcare Fraud**.

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

Report concerns:

- Visit **Anthem.com**, scroll to the bottom footer and click on "**Healthcare 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.
- Calling the Provider Services Department at the phone number provided in *Section 2, Quick References*, under *Provider Services*. Click on this link: **Contact Information**

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 does not 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 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 Members ID (Identification) card
- Relocating to out-of-service Plan area and not letting the Plan know
- Using someone else's ID card

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

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

Examples Of **Provider/Facility** fraud, waste and abuse

- 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
- Directing Members from one managed care organization (MCO) to another MCO
- Falsifying documentation, such as change dates of receipt or approval
- 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 which should be covered by a single comprehensive procedure code
- Upcoding – when a Provider bills a health insurance payer using a procedure code for a more expensive service than was actually performed

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

- Name, address, and phone number of Provider
- Name and address of the facility (hospital, nursing home, home health agency, etc.)
- Medicaid number of the Provider and facility, if 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 healthcare fraud and how to aid in preventing it, visit: **Fight Healthcare Fraud**.

Investigation Process

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

- **Written warning and/or education**: We send letters to the Provider and 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**: We review 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 or investigator evaluates claims prior to payment of designated claims. Edits in Anthem's Claims processing systems identify these Claims for review to prevent automatic Claims payments in specific situations.
- **Recoveries:** We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future claims, termination from our network, and/or further legal action.

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.

For your protection California law requires the following to appear in this document:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Recoupment/Offset/ Adjustment for Overpayments
Anthem shall be entitled to offset claims and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider or Facility ("Overpayment Amount") against any payments due and payable by Anthem or any Affiliate to Provider or Facility with respect to any Health Benefit Plan under this Agreement or under any Agreement between Provider and an Affiliate regardless of the cause.

Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility.

If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of the notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement.

Should Provider or Facility disagree with any determination by Anthem or a Plan that Provider or Facility has received an overpayment or improper payment, Provider or Facility shall have the right to appeal such determination under Anthem's procedures set forth in the Provider Manual, provided that such appeal shall not suspend Anthem's right to recoup the Overpayment Amount during the appeal process unless required by Regulatory Requirements. Anthem reserves the right to employ a third-party collection agency in the event of non-payment.

If Anthem has paid a clean claim for Capitated services, then after notice, Anthem will deduct such payment (including any interest payable under Health & Safety Code Section 1371), from any money due from Anthem to Provider, from a future Capitation payment. The notification will require Provider may review claim information through Availity. The current notification process allows the Provider 45 days to respond, prior to activating the deduction from capitation.

Misrouted Protected Health Information (PHI)

Providers 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 is not currently treating. PHI can be misrouted to Providers by mail, fax, e-mail, or electronic remittance. Providers are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers permitted to misuse or re-disclose misrouted PHI. If Providers cannot destroy or safeguard misrouted PHI, Providers must contact Provider Services to report receipt of misrouted PHI at the phone number provided in *Section 2, Quick References,* under *Provider Services*.
Click on this link: **Contact Information**

Provider Data Solutions

Provider Change Request
Provider Data Solutions (PDS) facilitates the data maintenance of Provider information for medical groups, facility Providers, physicians and ancillary network Providers.

Anthem uses the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all professional and facility care providers. Availity Essentials Provider Data Management (PDM) is now the intake tool for care providers to submit demographic change requests, including submitting roster uploads. Availity PDM replaced all other intake channels for demographic change requests and roster submissions.

- Include specific addresses, Tax ID numbers, and telephone numbers for each location
- Submit practice changes within 30 calendar days of change
- W-9 is required for Tax ID or Tax ID name change and Remit address changes. Visit the IRS Website at **irs.gov** to obtain a W-9 form
- To add a Provider, a profile sheet must be included in the request.

Compliance With Federal Laws, Audits and Record Retention Requirements
Medical records and other health and enrollment information of Members must be maintained under established procedures that:

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

In addition to the obligation to safeguard the privacy of all 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.

Electronic Data Interchange (EDI)

Anthem E-Solutions
Anthem uses Availity as our EDI gateway for managing all Electronic Data Interchange (EDI) transactions as a no cost solution. EDI, including Electronic Remittance Advices (835) and Electronic Funds Transfer (EFT) allows for faster, more efficient, and cost-effective ways for Providers and employers to do business.

Payer ID
A Payer ID is used to route EDI transactions to the appropriate payer. The **Availity Payer ID List** is available on Availity.com. If a Provider or facility uses a clearinghouse, billing service or vendor, please work with them directly to determine Payer IDs.

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

Ways to Submit to the Availity EDI Gateway
Availity's 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. Requires the vendor to have a connection, to the Availity EDI Gateway

EDI 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 you are already an Availity Essentials user, choose **My Providers**, then **Transaction Enrollment** or choose **Register** if you are new to Availity Essentials.

Electronic Remittance Advice (835)
Use Availity to register and manage ERA account changes with these three easy steps:

- Log in to Availity at **Availity.com**
- Select **My Providers**
- Click on **Enrollment Center** and select **Transaction Enrollment**.

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

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

Use EDI to submit corrected claims.

For corrected electronic claims use one the following frequency codes:

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

EDI segments required:

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

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

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 deposits are 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), use EnrollSafe at **enrollsafe.payeehub.org** to register and manage EFT account changes.

You can also access EFT enrollment through our website at **Anthem.com**. Select **For Providers** from the top horizontal menu, select **Electronic Data Interchange (EDI)** under **Claims**. Next, scroll down to select **California**, once on the EDI page scroll to the bottom section EDI Resources and select the Electronic Funds Transfer tab.

Virtual Credit Cards (VCC)
In lieu of paper checks, Providers and Facilities will be issued a VCC that is processed as a credit transaction from your credit card terminal – the same terminal used for patient payments. There could be fees associated with credit card transactions based on the agreement between the Provider or Facility and their card service provider. VCC transactions are not as fast as EFT payments and are issued for each Claim payment.

Contact Availity Essentials
Contact Availity Essentials Client Services with any questions at the phone number provided in *Section 2, Quick References,* under *Availity Essentials Client Services*.
Click on this link: **Contact Information**

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, from registration to ongoing support.

Availity Batch EDI Standard Companion Guide – This Availity EDI Guide supplements the HIPAA TR3s and describes the Availity Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions related to Availity.

Availity Essentials Registration Page – Availity Essentials registration page for users who are new to Availity Essentials.

X12 External Code Listing – X12 code descriptions used on EDI transactions.

Submission Requirements

- Medical groups must report on all physicians, hospitals, facilities, and other healthcare professionals rendering care to Anthem HMO Members for capitated services, including contracting specialists and other referral healthcare professionals. Contracted entities that are required to submit encounter data must submit signed documents that certify the accuracy, completeness and truthfulness of the data.
- Medical group shall submit encounter data for all services covered under capitation, electronically, within 45 calendar days of the date of service.
- Submit capitated services only. Do not co-mingle capitated and non-capitated services in the same file. Payable services should be submitted as claims.
- Submit file one time only. Do not submit duplicate files.
- Submit encounter one time only; exception is a correction (see next item). Do not submit duplicate encounters.
- If a file contains encounters with errors, submit the corrected encounters only.
- Do not correct the encounters within a previously submitted file and return the entire file.
- Corrected encounter submissions must be submitted using the appropriate frequency code.
- Submit files by contracted Line of Business *(Commercial)*, when possible.

Data Element Requirements

Capitated encounter data must include all of the same data elements and information required for non-capitated services. Encounters must include, but are not limited to the following:

- Rendering Provider name and National Provider Identification (NPI) number and Taxonomy Code. Do not submit with the MEDICAL GROUP TIN and/or NPI
- Billing Provider TIN and NPI
- Billing Provider Street address, city, state, and 9-digit ZIP code. Do not submit P.O. Box address or Lock Box
- Attending Provider National Provider Identification (NPI) number and Taxonomy (Institutional services)
- Use of Standard Code Sets – All Providers are required to submit encounters using Centers for Medicare & Medicaid Services (CMS) HIPAA compliant code sets, which include current ICD codes, CPT codes, HCPCS, NDC, and Place of Treatment Codes as appropriate
- Procedure Codes (HCPCS and CPT) with revenue codes for all Hospital outpatient services
- Inpatient Encounters must include Room and Board Revenue Code and corresponding Day(s) Stay
- Procedure codes, diagnosis codes need to be age and gender appropriate
- Dollar value for services rendered. Do not bill zero value

- Professional and technical component modifiers
- Copayment/Coinsurance/Deductible information
- Accurate Member Identification number with alpha prefix, gender, date of birth
- Member Plan Group Number.
- Member street address, city, state, and ZIP code

E-Solutions for Encounter Data Submissions
Anthem has contracted with third-party vendors/clearinghouses to establish the necessary connectivity with contracted physicians, hospitals, facilities, and other healthcare professionals for electronically submitting HMO encounter records.

The vendors/ clearinghouses accept various HMO encounter data formats from physicians, hospitals, facilities, and other healthcare professionals and translate the data into the required HIPAA format for Anthem.

These vendors/clearinghouses work with each medical group identified by Anthem for implementing electronic encounter data submissions. The process is:

- Anthem notifies the physician or other healthcare professional that the encounter data records will be submitted to the contracted vendor/clearinghouse.
- The vendor/clearinghouse initiates the electronic encounter data submission process by contacting the physician or other healthcare professional. This process includes:
    - System analysis
    - Enrollment for electronic
    - Testing
    - Implementation and support

Accepted Formats
The vendor/clearinghouse receives encounter data in various formats. Contact them to discuss options. They will translate various formats into the appropriate HIPAA compliant ANSI-X12 format for transmission to Anthem.

Billing For Non-Capitated Services

The non-capitated services healthcare Provider may bill Anthem directly. Anthem reimburses the healthcare Provider according to turnaround times outlines within the provider's contract.

Note: All hard-copy claim submissions must be billed on CMS-1500 Claim forms. Anthem reimburses the medical group within 45 working days of receipt of a clean, undisputed claim that is accompanied by the medical group's authorization, if the claim is submitted no more than 12 months from the service date.

Medical groups must submit claims to Anthem within 12 months from the date of service or Anthem may refuse payment.

Claims that are filed beyond the timely filing period, should include proof of timely filing or it will be denied accordingly. The patient is not responsible for this amount. If it is believed that the claim was filed within the contracted timely filing guidelines, evidence of timely filing should be attached to the original claims in

a timely manner for consideration. If the claim is denied, ***do not resubmit the original claim***. Attach proof of timely filing to the Anthem mail back or denial EOB can be submitted.

Anthem may accept the following as evidence of timely electronic submission:

- Clearinghouse report (e.g., NEIC) of acceptance by Anthem
- Request for Additional Information form (from Anthem)
- Anthem generated Level 1 Acknowledgement Report; if you need your report recreated during the first 30 days after submission, contact Availity Essentials Client Services at the phone number provided in *Section 2, Quick References,* under *Availity Essentials Client Services*.
  Click on this link: **Contact Information**
- Claim denial letter or EOB from Anthem for EDI claims that could not be processed
- Copy of Anthem's dated letter to Provider requesting a resubmission
- Anthem batch number for claims (or other identifying information) or error listing. Anthem may, for example, accept the following as evidence of timely hard copy submission
- Computer-generated claim transaction history from a billing system with the Anthem name
- Must include billing history and history of timely follow-up attempts made within contracted timely filing guidelines
- Dated request for additional information form (from Anthem)
- Claim denial letter or EOB from Anthem

Anthem reserves the right to use its sole discretion in determining whether the information supplied is acceptable for timely filing purposes.

Link: **Timely Filing Acceptable Forms of Proof**. This link will direct you to the Provider Education and Training Page. Scroll down and select Supplemental Education Materials (SEMs)>SEM 21, Timely Filing Acceptable Forms of Proof.

Claim Inquiry
Anthem will reconsider rejected or returned claims on the physician's or healthcare professional's request.

Secure Messaging – Availity Essentials (Availity)
Availity Essentials provides the opportunity to "ask a question" about a claim online. You can send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is a feature accessed at **Availity.com**. This functionality is only available on Availity.

For more information about Secure Messaging, refer to the Secure Messaging section on Availity.

Hard Copy Claims Submission
When submitting hard copy claims for Anthem non-capitated services, submit claims using the authorization form in use at your medical group. Attach the authorization form to the claim(s) and mail them to the Exela Technologies address provided in *Section 2, Quick References,* under *Exela Technologies. Click on this link:* **Contact Information**

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

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

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

Make the Most of Electronic Coordination of Benefits (COB) Submissions
Availity is Anthem's designated electronic data interchange (EDI) Gateway. Availity provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. To learn more, contact the EDI vendor or go to **Availity.com**.

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

Third-Party Liability
The capitated Provider should question a Member for possible third-party liability in all injury cases. Often, the Member will not mention that this liability exists, since they receive complete care from the medical group and may not feel it is necessary to pursue a third-party liability case.

Anthem HMO plans provide that Anthem may recoup benefits for medical care that is received in connection with any illness, injury, or condition for which a third party may be liable. In such cases, the medical group provides benefits to the Member, subject to certain limitations.

Anthem will be entitled to collection on its lien, even if the amount recovered by or for the Member (or their estate, parent, or legal guardian) or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

Medical Group Criteria Organization

The following criteria must be met for a medical group to be considered to participate in the Anthem HMO network:

A medical group must be a legal entity, such as a corporation, collaboration, or sole proprietorship, recognized in the State of California. It must have been in existence and operating for at least two (2) years, be the direct successor of an entity with such experience, or otherwise be able to demonstrate that the medical group's physicians operate together efficiently and harmoniously.

The medical group must demonstrate that it can grow as its Member population grows and will be at risk for the services it provides and controls, including referrals.

Location
The medical group must be in a demographic area with significant market potential and have the capability to attract enough of that market to make a significant economic contribution to the program. Demographic factors that are considered include, but are not limited to:

1. Number, size, and type of employers in the area.
2. The presence of other physicians, hospitals, or healthcare professionals.
3. Accessibility of care.
4. Proximity to other physicians, hospitals or other healthcare Professionals with existing Anthem contracts.

Facilities/Operations
The medical group's outpatient and ambulatory care facilities must be of sufficient size and equipped in a manner that provides high-quality medical care to Anthem Members. Each site must be self-contained. If the medical group desires to operate a satellite, the satellite must provide full primary care for its Members, and Anthem must pre-approve each site.

Medical groups must have a central medical records system. A central appointment desk is encouraged. Medically Necessary emergency services must be available to Members 24 hours a day, 7 days a week.

Note: A hospital that reduces or eliminates emergency services must notify the government and health plans with which it contracts. The health plan's Members must be notified by the health plan or by the medical group. The notification must include a directory of alternate hospitals that continue to provide emergency services.
The medical group must be able to provide a choice of PCPs to oversee and coordinate overall Member healthcare. Access to specialists must be provided to Members on referral by the PCP or by direct access, as determined by medical group's policy. In addition, the medical group must provide:

1. A Medical Director or lead physician to oversee and manage healthcare delivery to all Members.
2. An Anthem HMO Coordinator for Members.
3. Appropriate health education for Members, including disease prevention and wellness programs, must be made available to Anthem Members according to the following specifications:
    - 0 to 500 Members – Minimum of one (1) program per year
    - Over 500 Members – Minimum of two (2) programs per year

If the medical group has one or more satellites (a site separate from the principal place of business that it is dependent on, and responsible to), the satellite must meet the Anthem satellite criteria below, and be approved by Anthem, before it can be designated as an Anthem HMO satellite.

Satellite Medical Group Criteria
Following is the minimum criteria for a medical group satellite to be included in Anthem's HMO network. The primary considerations in satellite approval are quality of care and convenience to Anthem Members.

1. The satellite clinic must have, at a minimum, one (1) full-time equivalent PCP. The satellite must meet the ratio of one (1) full-time PCP equivalent per 2,000 patients served, with at least one physician having one of the following specialties available at all times during the regular business hours Monday through Friday:
   a. Family Practice
   b. General Practice
   c. Internal Medicine

2. All routine primary care services must be available at the satellite. Routine X-ray and laboratory services must be available at the satellite location or contracted in the satellite's immediate vicinity. If the satellite is not self-contained, the distance between the satellite and the main clinic (parent medical group) must be within reasonable driving time, according to local community standards. The satellite must provide access to specialists.

3. Most specialty referrals should be to the parent medical group. If the specialty required is not available at the parent medical group, referral contracts should be made as close to the satellite as practical.

4. Medical records can be maintained at the satellite if data can be easily communicated to and from central medical records, at the parent medical group. Documented procedures for such communications should accompany the satellite approval application.

5. Satellites are required to have ample parking.

6. A physician permanently based at a satellite should be designated as an associate Medical Director and trained by the medical group's Medical Director of Anthem operations. Written procedures indicating the functions delegated to the associate Medical Director and those retained by the parent medical group's Medical Director should be prepared and submitted with the satellite application.

7. A receptionist or other non-physician employee at the satellite must be trained to function as the Anthem HMO coordinator, on a part-time basis. Because geographic and demographic situations vary from one medical group to another, Anthem considers special circumstances that may exist for any individual satellite approval request. However, Anthem's decision on all applications is final.

Capacity
The medical group's existing and reasonably projected physical capacity must be large enough to provide primary healthcare for the projected number of Members served by the medical groups. Factors to be considered include growth forecast and record, floor space, parking, equipment, patient load per physician, financial standing, the number of HMOs that contract with the medical group, contractual arrangements between the medical group and individual specialists, previous ability to obtain and retain physicians and ancillary personnel, and professional standing.

The medical groups existing, and reasonably projected staff capacity must be of sufficient size and flexibility and will provide plan Members with high-quality healthcare as program enrollment increases.

PCPs must be Members of the medical group, except for those who are serving an initial probationary period. The probationary period may not be longer than two (2) years.

The medical group has a responsibility to accept all Members, until such time the medical group has provided Anthem with a 90-day written notice that it has reached maximum capacity, or that it anticipates reaching maximum capacity within 90 days. The maximum capacity of the medical group will be reduced only upon a 90-day written notice to Anthem, demonstrating that it has reached maximum capacity for all HMO Members.

Staff/Qualifications
All medical group physicians who treat Members must have an unrestricted current license to practice in the State of California. In addition, medical group physicians must be board-certified by the American Board of Medical Specialties (ABMS) or have fully completed a residency in the specialty they are marketed for.

The minimum acceptable full-time equivalent of a PCP is based on a patient load per physician of not more than 2,000 patients. A PCP is a physician who completed residency or is board certified by ABMS in pediatrics, internal medicine, OB, general practice, or family practice, and agrees to the medical group's specific requirements regarding PCP responsibilities. Exceptions are decided only on a formal basis and/or in accordance with applicable State laws. Exceptions must be reviewed by the Anthem Credentialing Committee.

Applicants who are Medical Doctors (MDs) and doctors of Osteopathy (DOs) must be board certified (as defined by the American Board of Medical Specialties [ABMS] or the American Osteopathic Association [AOA]) in the clinical discipline for which they are applying or, in the absence of such certification, must not raise a reasonable suspicion of future substandard professional conduct or competence. Individuals will be granted five (5) years after completion of their residency program to meet this requirement. However, individuals who are no longer eligible for board certification may not receive exemption from this requirement.

Each medical group should have at least one pediatrician and one OB/GYN, in addition to at least three remaining classes of PCP (i.e., family practitioners, general practitioners and internists).

Anthem has a *ReadyAccess* program. The program has two components that provide different means of accessing a specialist: Speedy Referral and Direct Access. Additional information on ReadyAccess is located in the **General Benefits** section of this Provider manual.

The medical group must have the capability to refer Members to specialists. Non-board-certified specialists must have completed, at a minimum, a fellowship in the specialty field of practice and the medical group must have a credentialing policy in place that is approved by the Anthem Credentialing Committee.

Contracts must be on file for each specialist not part of the medical group and each contract must be approved by Anthem. The following certified specialists (at a minimum) must be readily and conveniently available to serve Members as medically indicated on referral:

- Cardiologist
- Cardiovascular Surgeon
- Dermatologist
- Hematologist/Oncologist

- Neurologist
- Neurosurgeon
- Obstetrician
- Orthopedic Surgeon
- Orthopedist
- Thoracic Surgeon

Contracting referral specialists must be located within reasonable proximity to the medical group to ensure ease of access by Members. Contracts must provide that:

An Anthem Waiver or the medical group's waiver form (including all DMHC data requirements) must be signed by the Member for all non-covered services prior to services being rendered. The form must be completed accurately and signed by the Member, otherwise the Member may not be balanced billed. *Link:* **Member (Patient) Responsibility Agreement – Waiver Form**. Filter **Category** by **Claims & Appeals** scroll down to **Member (Patient) Responsibility Agreement – Waiver Form**.

The medical group's waiver form MUST include the following data elements:

- Member (Patient) Name
- DOB
- Subscriber ID
- Group Number
- Provider
- Provider NPI/Tax ID
- Provider Phone
- Date(s) of Service
- Description of Service and/or supply
- Members (Patient's) Responsibility

1. Specialists agree to accept Anthem Members on referral from the medical group's PCPs.

2. Specialists agree to accept payment from the medical group for services rendered to Anthem Members as full payment and agree not to "balance bill" Anthem Members for such services.

3. Specialists agree not to hospitalize (unless emergency conditions exist) Anthem Members without the referring PCP's agreement and the Medical Director's authorization.

4. Specialists will maintain in-force adequate malpractice insurance and hold the medical group and Anthem harmless, as well as meet the credentialing criteria of the medical group and Anthem. *Note: Contracting referral specialists must be located within reasonable proximity to the medical group or physician practice location to ensure ease of access by Members.

5. The medical group demonstrates that it can make available to Members, other licensed, qualified health professionals necessary to provide all medical services that a medical group agrees to provide Members in the Provider Agreement. Such professionals will include, but are not limited to:
    a. Optometrists or Ophthalmologists

b. Oral Surgeons
c. Podiatrists
d. Therapists (physical, speech, occupational)

6. The medical group provides or contracts for qualified, licensed nursing personnel and X-ray and laboratory technicians in sufficient numbers to serve Anthem Members.

7. The medical group must be willing to make maximum use of qualified, licensed physician's assistants, nurse practitioners or other paramedical personnel to assist the PCPs.

8. On request, the medical group agrees to make available to Anthem, a copy of the agreement(s) executed between the medical group and the health professionals contracted to provide referral services.

9. The medical group must complete operational credentialing policies and procedures, in accordance with those outlined in the Anthem medical group Audit and Review Tool and Credentialing Guideline workbook. All contracted physicians must be credentialed by the medical group.

Utilization Review
For more information, see the **Medical Management Program & Policies** section of this Provider manual.

Payments And Risk Assumptions

The medical group must accept previously negotiated payment amounts as payment in full for all capitated services as defined in the contract rendered to Members, when covered under the program, and assume the risk for medical group physician's responsibilities. The medical group must also provide or arrange, for all covered healthcare services.

Administration
The medical group must have a workable internal administrative mechanism for both distributing income derived from the program to full-time participating physicians, and for reimbursing physicians for authorized services rendered to Anthem Members. The medical group must be willing to comply with Anthem Grievance and Appeals Procedures and must assign staff to assist Members with selecting a PCP.

The medical group must provide Anthem with encounter information to facilitate reporting and develop actuarial data in a format acceptable to Anthem, as described in detail in the **General Benefits** section of this Provider manual.

The medical group will conduct site visits to each physician's office contracted with the medical group, in accordance with procedures developed by the medical group and approved by Anthem. The medical group has responsibility for overall administrative duties. Anthem will be evaluating and monitoring the administration that is part of the medical group Oversight.

Financial Condition
The medical group must be able to demonstrate that it is financially sound. Audited financial statements, balance sheets, and/or other financial information must be available on request, as agreed upon and pursuant to the Provider Agreement. The medical group is subject to an Anthem audit of that portion of the books/records that pertains to program business. The medical group must make books and records relating to program business accessible to Anthem, state and federal regulatory agencies.

Medical Group Oversight

Anthem's California Commercial Targeted Delegation Oversight Program (TDOP) has established a framework for Anthem to monitor and oversee the performance of its delegated HMO Physician groups. The TDOP is managed by a multi-disciplinary committee called the Provider Performance Advisory Committee (PPAC).

On a monthly basis PPAC will review physician group performance on specific metrics related to, Network Adequacy, Quality Management, Utilization, Encounter Submissions, Grievance and Appeals, Delegation Oversight, HMO Clinical Oversight and Commercial Risk Adjustment. To view **HMO Provider Performance Metrics**, click on the following link: **HMO Provider Performance Metrics Defined**.

Performance deficiencies identified may result in an Advisory letter issue by PPAC requesting a corrective action plan (CAP), which requires physician groups to take action to improve. If performance does not improve as expected and/or as agreed, an escalation process may be activated. If necessary, PPAC will take formal action to remediate noncompliance, which may include, but is not limited to, the following:

- A second notice of continued deficiency
- Off Cycle Joint Operating Committee (JOC)
- Escalation to Plan and Physician Group Leadership
- A reduction in capitation
- A freeze on enrollment
- Revocation of delegation
- Contract termination

All actions taken by PPAC is subject to the terms of the Physician Group's contract.

Quality Management/Member Rights and Responsibilities
For more information, see the **Quality Improvement Program** section in this Provider manual.

Utilization Management (UM)

Anthem delegates UM to medical groups that demonstrate compliance with Anthem established standards for performing UM functions, adhering to Anthem policies, accreditation standards and State and Federal regulatory requirements. The medical group must have structures and processes that are clearly defined, and responsibilities assigned to appropriate Individuals. This includes a designated senior physician who oversees the UM program and chairs the Utilization Management Committee (UMC), UM resource staff to support the program's needs, as well as a governing body providing oversight of all the group's programs. UM includes policies and procedures for:

- UM Program
- Utilization Review Process
- Use of appropriate health professionals
- Use of utilization review criteria
- Disclosure of policies, procedures, and criteria
- Communication services for Members and practitioners
- Timeliness of UM decisions and notification

- Post-Stabilization Care
- Pend/Extension of UM decisions
- Notification of reviewer availability to discuss UM denial decisions
- Handling requests for Experimental and Investigational treatment
- Referral cancellations
- Standing specialist referrals
- Second Opinion
- HIPAA compliance
- Provisions of Language Assistance Program (LAP)
- Member notification of specialist terminations
- Inter-rater reliability evaluation
- Use of board-certified consultants to review cases as needed
- Affirmative statements regarding incentives
- UM System Controls to protect and monitor data from unauthorized modification
- Process for referring Member complaints to Anthem

Credentialing/Peer Review

Anthem delegates credentialing to medical groups that demonstrate compliance with Anthem established standards for the credentialing function, including all applicable accreditation standards and State and Federal regulatory requirements. The delegated medical group must have structures and processes in place that are clearly defined and followed. The process must include a designated senior-level physician who oversees the Credentialing Review (CR) program and chairs the CR Committee (CRC), CR resource staff to support the CR program's needs and policies and procedures that include, but are not limited to:

- Identification of practitioners to be credentialed/re-credentialed, eligibility criteria, and primary source verifications for initial credentialing and recredentialing at least every three (3) years. This includes committee review of credentialing files for determination of practitioner affiliation or re-affiliation
- Process for making credentialing and recredentialing decisions and notifying practitioners of the decision within 60 days of the CRC decision.
- Process for securing the confidentiality of all information obtained in the CR process, except as otherwise provided by law.
- CR system controls to protect and monitor data from unauthorized modification.

The medical group must have a credentialing/ peer-review mechanism to monitor the patient care provided to Members by practitioners to ensure quality of care and service. Credentialing includes, but is not limited to, the identification of practitioners to be credentialed/re-credentialed, eligibility criteria, and primary source verification for initial credentialing and recredentialing at least every three (3) years. This includes committee review of credentialing files for determination of practitioner affiliation or re-affiliation.

Peer review includes procedures for identifying issues of quality of care and service, defining the range of actions that may be taken to improve performance, suspension, or termination of practitioner contracts; reporting serious quality deficiencies to appropriate authorities; ongoing sanction and complaint monitoring; and a fair hearing process.

The process for identifying quality of care and service issues includes:

- Monitoring QM activities
- Complaints/appeals and Member satisfaction
- Encounter data
- Utilization statistics to assess appropriate utilization
- Medical record and office review to assess access
- Medical record-keeping practices
- Continuity and coordination of care
- Adherence to practice guidelines
- Compliance with Occupational Safety and Health Administration (OSHA) requirements
- Risk-management policies, and healthcare education

Provider Dispute Resolution

Claims Adjudication
The medical group will accept and adjudicate claims for healthcare services provided to Anthem Members in accordance with the provisions of the *California Health & Safety Code* Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8; and Title 28 of the *California Code of Regulations* Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4.

Dispute Resolution
The medical group will establish and maintain a fair, fast, and cost-effective dispute resolution mechanism to process and resolve Provider disputes in accordance with the provisions of *California Health & Safety Code* Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.38, 1371.4 and 1371.8 and Title 28 of the *California Code of Regulations* Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4.

Reporting Requirements
Medical groups submit a Quarterly Claims Payment Performance Report (Quarterly Claims Report) to Anthem within 30 calendar days of the close of each calendar quarter. The Quarterly Claims Report will, at a minimum, disclose the medical group's compliance status with the *California Health & Safety Code* Sections 1371, 1371.1, 1371.2, 1371.22, 1371.35, 1371.36, 1371.37, 1371.4 and 1371.8*;* and Title 28 of the *California Code of Regulations* Sections 1300.71, 1300.71.38, 1300.71.4 and 1300.77.4. In the event the DMHC has promulgated a required report format, a medical group will submit its Quarterly Claims Report in this format. The medical group's Quarterly Claims Report will include a tabulated record of each Provider dispute it received, categorized by date of receipt, and including the identification of the Provider, type of dispute, disposition and working days to resolution, as to each Provider dispute received. Each individual dispute contained in a Provider's bundled notice of Provider disputes will be reported separately to Anthem.

Each Quarterly Claims Report must be signed by and include the written verification of a "principal officer" (as defined in the Claims and Dispute Regulations) of the medical group, stating that the report is true and correct to the best knowledge and belief of the principal officer.

Records of Dispute Resolution Mechanism
The medical group will make available to Anthem and the DMHC all records, notes, and documents regarding its Provider dispute resolution mechanism(s) and the resolution of its Provider disputes.

Provider Right of Appeal
Providers have the right to appeal clinical decisions. Refer to **Section 12 Grievance, Appeals and Disputes.**

Right to Assume Responsibility for Claims Processing
The medical group authorizes Anthem to assume responsibility for the processing and timely reimbursement of Provider claims if the medical group fails to timely and accurately reimburse its claims (including the payment of interest and penalties). Anthem' assumption of responsibility for the processing and timely reimbursement of the medical group's Provider claims may be altered to the extent that the medical group has established an approved corrective action plan consistent with *Health and Safety Code* Section 1375.4(b)(4). In the event Anthem assumes such responsibility, adjustments to previously agreed monthly payments by Anthem, will occur as agreed to, in the Provider Agreement.

Right to Assume Responsibility for Dispute Resolution
Anthem is authorized to assume responsibility for the administration of the medical group's dispute resolution mechanism(s) and timely resolution of Provider disputes, in the event the medical group fails to resolve its Provider disputes timely, including the issuance of a written decision. In the event Anthem assumes such responsibility, adjustments to previously agreed monthly payments by Anthem, will occur as agreed to in the Provider Agreement.

Balance Billing Prohibition
Except for applicable copayments, coinsurances and deductibles, the medical group will not invoice, or balance bill an Anthem Member for the difference between the medical group's billed charges and the reimbursement paid by Anthem for any covered benefit. Refer to the Anthem waiver section above under medical group Criteria Organization section.

Health Professionals
Anthem defines "physician" as a Doctor of Medicine (MD) or a doctor of osteopathy (DO) who is licensed to practice medicine or osteopathy in the state in which the care is provided. The following list of healthcare professionals are physicians, but only when:

- They are licensed to practice where the care is provided
- They are rendering service within the scope of that license and
- Providing service for covered benefits provided by one of these physicians:
    - Acupuncturist
    - Audiologist
    - Chiropractor (DC)
    - Clinical Psychologist
    - Clinical Social Worker (CSW)*
    - Dentist (DDS)
    - Dispensing Optician
    - Marriage and Family Therapist (MFT)*
    - Nurse Midwife*
    - Nurse Practitioner
    - Occupational Therapist (OTR)*
    - Optometrist (OD)
    - Physical Therapist (PT or RPT) *

- Physician Assistant
- Podiatrist or Chiropodist (DPM, DSP or DSC)
- Psychiatric Mental Health Nurse*
- Respiratory Care Practitioner (RCP)*
- Speech Pathologist
- Registered Dietician (RD), for the provision of Diabetic-Medical Nutrition Therapy only

*****These healthcare professionals are covered services when they are available within the selected medical group or by referred to by a PCP within the selected medical group.

Primary Care Physician (PCP)
A primary care physician (PCP) is a physician selected by a subscriber to (1) provide their initial and primary care and (2) coordinate multi-disciplinary services, preventive care services, acute and chronic conditions care, and psychosocial services. As the first physician a Member contacts when a medical problem occurs, PCPs act as gatekeepers by initiating specialist referrals and hospitalizations and maintaining the continuity of patient care throughout the Members treatment.

The PCP is responsible for providing patients with 24-hour, on-call coverage, as well as same-day access to urgent care. Members may select their PCPs from any open medical group within the service area designated in their EOC.

PCPs can be general and family practitioners, internists, or pediatricians. OB/GYNs who meet Anthem eligibility criteria may be designated by Anthem as PCPs, if they so desire. All PCPs must be trained and competent to perform the following services:

1. **Preventive Care Service**
   This includes appropriate examinations, immunizations, and counseling, as set forth by the United States Preventive Service Task Force. For additional information on these guidelines, contact your Anthem quality management Representative.

2. **Acute And Chronic Diseases**
   Acute and chronic disease management, including, but not limited to:
   a. Allergies and Asthma. Diagnosing and treating acute and chronic allergies and asthma. Measuring peak expiratory flow
   b. Cardiovascular Disease. Uncomplicated hypertension, hyperlipidemia, stable angina, EKG interpretation, evaluation, and peripheral vascular disease (venous and arterial)
   c. Dermatology. Diagnosing and treating common skin lesions (e.g., rashes, warts, keratosis, etc.). Skin biopsy and excision, as appropriate
   d. Endocrinology. Diabetes mellitus controlled by diet, oral medication or insulin, and thyroid dysfunction
   e. Gastroenterology. Peptic ulcer disease, gastro-esophageal reflux, irritable bowel syndrome, acute abdomen differential diagnosis, including gynecological disorders, hemorrhoids, acute hepatitis and cirrhosis
   f. Gynecology. Routine pelvic examinations with Pap smear, diagnosing and treating sexually transmitted diseases and abnormal vaginal bleeding. Diagnosing pregnancy and family planning
   g. Hematology. Differential diagnosis and treatment anemias and other hematologic conditions
   h. Infectious Diseases. Diagnosing and treating common infectious diseases

i. Neurology Headaches (migraine and muscle tension) and seizure disorders (stable and controlled)
j. Ophthalmology. Corneal abrasions, conjunctivitis, sties, and visual acuity screenings
k. Orthopedics (non-operative). Strains, sprains, tendonitis, bursitis, sprain and simple fractures splinting, and low back pain. Initial evaluation and treatment
l. Psychosocial. Psychiatric assessment and initial intervention, recognition, and management of drug and alcohol dependence and depression
m. Pulmonology and Otolaryngology. Diagnosing and treating acute upper and lower respiratory conditions, chronic upper and lower respiratory conditions, otitis media, and tonsillitis
n. Rheumatology. Initial musculoskeletal disorders evaluation
o. Surgery (basic). Basic management and surgical procedures, laceration suturing, cysts, and abscess incision and drainage
p. Urinary. Urinary tract infections, kidney stones

OB/GYN as PCP
An OB/GYN who meets all applicable eligibility requirements qualify to practice as a PCP. They then have the same rights and responsibilities of all other PCPs when providing care to Anthem Members, including direct access by female Members wishing to choose an OB/GYN as a PCP.

Eligibility
Eligibility requirements of an OB/GYN to provide services as a PCP require a written attestation that they are qualified to provide primary care services. Eligible OB/GYNs must accept the broader requirements of primary care, including:

- Accessibility to a standard consistent with other PCPs
- Accountability
- Comprehensiveness
- Continuity of Care
- Coordination of Care

Eligibility criteria may include complete physician credentialing, medical group participation, educational requirements, and a willingness to abide by all referral and authorization requirements.

If an OB/GYN is determined to be ineligible, Anthem will document the reasons for the decision. Some reasons may include lack of adequate primary care training, unwillingness to abide by Anthem procedures and requirements, or the number of OB/GYN PCPs in the network is sufficient.

Continuation Of Care When A Physician Terminates, Or As A New Enrollee
Anthem will provide continuity of care/completion of covered services in accordance with the requirements and process set forth by California law, when the contract between the HMO medical group and Anthem terminates. On the effective date of a contract termination, Anthem's Member may request continuity of care/completion of covered services by calling the Customer Service number on the Member's identification card or filling out the Continuity of Care/Transition of Care Request Form.

Go to **Anthem.com**, select **For Providers**, select **Forms and Guides** (under the Provider Resources column). Type **Continuity of Care** in the **Search Anthem.com** bar. In the left margin, under **Narrow your results**, choose **Providers**.

Please note that if a contract terminates between the provider and the HMO medical group, continuity of care is handled by the HMO medical group.

While Members have the option to request continuity of care with their current Provider or to ask for further explanation of their rights, eligibility for continuity of care depends on factors outlined in the Members EOC. Continuity of care/completion of covered services also applies to certain newly covered enrollees who are in the middle of a course of treatment and at no choice of their own, was switched to Anthem, and their provider is non-participating. Continuity of care/completion of covered services includes:

- In an active course of treatment for an acute medical or behavioral health condition
- Through current period of active treatment or up to 90 days, whichever is less
- In an active course of treatment for a serious chronic condition (per CA Health & Safety Code
- §1373.96, not to exceed 12 months)
- Who are pregnant, regardless of trimester (through the postpartum period per NCQA standard QI 10.D2). For maternal mental health conditions, completion of covered services shall not exceed twelve (12) months from the diagnosis or from the end of pregnancy, whichever occurs later (per CA Health and Safety Code 1373.96).
- With a terminal illness
- Who is a child between the ages of birth and thirty-six (36) months
- With a surgery or other procedure that has been authorized by the plan or its delegated Provider, which is scheduled to occur within 180 days of the contract's termination or within 180 days of the effective date of coverage for a newly covered enrollee.

For more information regarding continuity/transition of care, refer to the Continuity of Care/Transition of Care Program subsection in the **Medical Management Program & Policies** section of this Provider manual.

Medical groups are required to provide notice of a specialist terminating from the group to Anthem Members in a course of treatment with that specialist. The medical group must assist these Members with transition to a new specialist, if continued care is needed.

The law requires health plans to provide a sixty-day (60) notice to HMO Members of their assigned PCP's termination. In order to ensure Members are notified timely, it is imperative that medical groups, hospitals and other contracting healthcare professionals inform Anthem of terminations pursuant to their respective agreements. Medical groups are also required, per the Anthem Provider Agreement, to provide at least 90 days prior written notification to Anthem of all PCP terminations.
Use Google Chrome to access this link to the Provider Maintenance webpage:
Provider Maintenance

Economic Profiling
Health plans completing economic medical group or physician profiling must file related policies and procedure descriptions with the DMHC and upon request, provide information to the physicians who are profiled, up to 60 days following their contract termination. (This requirement also applies to medical groups that complete economic profiling of other physicians).

Risk-Bearing Organizations: Financial Solvency
Health and Safety Codes Sections 1347.15, 1375.4, 1375.5 and *1375.6* require a process of enhanced financial monitoring of physician organizations by requiring these organizations to report financial statement information to the DMHC and the managed healthcare plan. Managed healthcare plans have an obligation to monitor the financial solvency of the physician organization. Refer to the **Medical Group Oversight** topic in this section.

Additionally, managed healthcare plans are required to share certain actuarial information with their contracted Providers. These plans are required to report information to the DMHC that is related to the financial risk they have assigned to their Providers.

Risk Arrangement Disclosure by Anthem
Notwithstanding any contrary provision in the Provider Agreement, Anthem will:

1. Disclose, through electronic transmission (or in writing, if agreeable to both the medical group and Anthem), on a monthly basis, within ten (10) calendar days of the beginning of each report month, the following information:
   - Members added or terminated under each EOC/contract served by the medical group
   - Member identification number
   - Name
   - Birth date
   - Gender
   - Address
   - Plan contract
   - Employer group identification
   - Third-party coverage, if known
   - Enrollment/ disenrollment dates
   - Medical group Site Code Assignment
   - Provider effective date
   - Changes to coverage
   - Office Visit Copayment
   - Deductible
   - Capitation amount per Member per month (PMPM)
   - PCP selection (if the medical group is an IPA)

2. Disclosure to the medical group, of the financial risk assumed under the Provider Agreement, the following information for every type of risk arrangement (e.g., Anthem HMO, Anthem POS) under the Provider Agreement:

   1371. All factors used to adjust payments or risk-sharing targets, including, but not limited to, the following: age, sex and plan factors.
3. Disclose, through electronic transmission to the medical group – on a quarterly basis, within 45 calendar days of the close of each quarter – a detailed description of every amount (including expenses and income) allocated to medical group and to Anthem under every risk-sharing arrangement.

4. Provide payments under all risk arrangements, excluding capitation, no later than 180 days after the close of the medical group's contract year, or the Provider Agreement termination date, whichever occurs first.

Anthem will provide for any deductions that Anthem may take from any capitation payment, with sufficient details to allow the medical group to verify the accuracy and appropriateness of the deduction.

Anthem Access Standards
Anthem endorses and promotes uniform regulatory access standards relating to the healthcare delivery of preventive care appointments, routine primary care appointments, urgent care appointments, emergency and access to after-hours care, behavioral healthcare, and key elements of telephone service for Members.

Anthem will collect data through various Member feedback methods such as telephone complaints or grievance and appeals. Additionally, in order to ensure adequate coverage and compliance with regulatory and accreditation standards Anthem conducts geographic analyses and Provider surveys in order to evaluate effectiveness of the medical group access compliance. All Providers affiliated with the medical group are contractually required to participate in the Provider Appointment Availability Survey (PAAS). Refer to the **Quality Improvement** section of this Provider manual, for this information.

Timely Access To Care Standards
The Access Standards for Medical, Ancillary, and Behavioral Health Professionals are listed below. The table identifies the timeframe standard for specific appointments. Please take a moment to review and share this vital information with your staff.

Access Standards for Medical Professionals and Ancillary Providers

Appointment Type	Maximum Wait Time after Appointment Request
Non-urgent Primary Care (PCP)	10 business days
Non-urgent Specialist Physician (SCP)	15 business days
Non-urgent appointment for ancillary services (for diagnosis or treatment of injury, illness, or other health condition)	15 business days
Urgent Care (not requiring prior authorization)	48 hours
Non-urgent appointments with Specialist Physicians (SCP)	15 business days
Urgent Care (that requires prior authorization) (SCP)Urgent Care (requiring prior authorization)	96 hours

- Providers who determine, while acting within the scope of his or her practice and consistent with professionally recognized standards, that the established wait time may be extended must note in the relevant record that a longer waiting time will not have a detrimental impact on the health of the member/enrollee.
- Providers are required to report information to Anthem regarding compliance with the standards, including responding to the Provider Appointment Availability Survey (PAAS), the Provider Satisfaction Survey, and the After-Hours Survey, and to other inquiries from Anthem to support other compliance monitoring strategies employed by Anthem. Providers must ensure that such reports are honest and accurate. See Section 1367.03(f)(1).

Access Standards for Behavioral Health and EAP Providers

Appointment Type	Maximum Wait Time after Appointment Request
Non-Life-Threatening Emergency Care	6 hours Direct members to 911 or nearest emergency room
Urgent Care (not requiring prior authorization)	48 hours
Urgent Care (requires prior authorization)	96 hours
Routine Office Visit/Non-urgent Appointment	10 business days (Psychiatrists)* 10 business days (Non-Physician Mental Health Care Providers/Substance Use Disorder) 10 business days from the prior appointment for those undergoing a course of treatment (Non-Physician Mental Health Care/Substance Use Disorder) 5 business days (EAP)

** The DMHC Timely Access standard is 15 Business days for Psychiatrists; however, to comply with the NCQA accreditation standard of 10 Business Days, Anthem uses the more stringent standard.*

Access Standards for After-Hours

Appointment Type	Maximum Wait Time after Appointment Request
Emergency Care Anthem Blue Cross expects every provider to instruct their after-hours answering service staff that if the caller is experiencing an emergency, instruct the caller to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the member to call 911 or go to the emergency room if the caller is experiencing an emergency.	Direct members to dial 911 or go to the nearest emergency room.
Urgent Requests	Available 24 hours /7days. Member to reach a recorded message or live voice response providing emergency instructions; and for non-emergent (urgent) matters a mechanism to reach a medical professional, or a practitioner (non-MD) with information as to when to expect a call back.

* The DMHC Timely Access standard is 15 business days for psychiatrists; however, to comply with the NCQA accreditation standard of 10 business days, Anthem uses the more stringent standard.

- The next available appointment date and time can be either In-Person or by Telehealth services.
- Only appropriately qualified staff, a physician, physician assistant, nurse practitioner or registered nurse are allowed to provide triage or screening clinical advice.
- A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant time-elapsed standard Listed in the chart above.

911 Emergency Care

Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency.

If a Member considers a medical condition to be an emergency, they should be instructed to call ☎ **911** or go to the nearest hospital emergency room immediately. Anthem covers emergency services that are necessary to screen and stabilize a condition.

Emergency Services

In-Area Emergency Care Service Area
The in-area emergency service area for a medical group is defined as the service area defined in the Provider Agreement of the medical group's main medical group location or the Primary Care Physician, to which the Member is assigned.

Emergency Services Payment Requirement Even If Unauthorized
Section 1371.4 of the *Health and Safety Code* imposes broad obligations to pay benefits for emergency services, even if care has not been authorized by the Members medical group. As long as federal or state law requires that emergency services be provided without first questioning the ability to pay, a healthcare service plan may not require that a physician, hospital, facility or other healthcare professional obtain authorization prior to rendering emergency services.

A medical group must pay emergency service Physicians, hospitals or other healthcare professionals (within the service area) for services rendered to Members in need of emergency care, until the care results in stabilization of the Members condition.

Note: If any medical group uses the answering machine message that tells Members to go to the emergency room if they believe they have an emergency, or a Customer Service representative advises the Member to go to the emergency room, this constitutes authorization, and the service must be covered.

An emergency medical condition, as defined by law, is:

1. A medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in one of the following:
    - Placing the Members health in serious jeopardy
    - Serious impairment to bodily functions
    - Other serious medical consequences
    - Serious and/or permanent dysfunction of any bodily organ or part
2. Emergency services also include services rendered in connection with active labor. Active labor means labor at a time at which either of the following occurs:
    a. There is inadequate time to affect the safe transfer to another hospital prior to delivery
    b. A transfer may pose a threat to the health and safety of the Member or unborn child

Emergency Services are:

1. Services provided in connection with initial treatment of a medical or psychiatric emergency.
2. The appropriate screening, examination and evaluation by a physician or other appropriate practitioner to determine if an emergency medical or psychiatric condition or active labor exists.
3. The care, treatment and surgery necessary to relieve or eliminate the diagnosed emergency medical or psychiatric condition.

The Requirements for Covering Emergency Services are:

1. The medical group is responsible for Members emergency care as defined in the Provider Agreement.
2. As long as federal or state law requires that emergency services be provided without first questioning the ability to pay, a health service plan or its contracted physicians, hospitals or other healthcare professionals may not require that a Member, physician, hospital or healthcare professional obtain authorization prior to rendering emergency services.
3. After the Member has received emergency services and is stabilized, the medical group must be able to provide 24-hour access for Members and physicians, hospitals or other healthcare professionals to obtain timely authorizations for medically necessary care (including follow-up care), when the treating physician believes that the Member cannot be safely discharged.
    a. A designated physician or surgeon of the medical group must be available for consultation to resolve requests for authorizations for continuing care.
    b. “Timely” assumes that a physician can be reached within 30 minutes.
4. If the treating physician made a reasonable, documented attempt to contact the medical group, and the medical group fails to respond in a timely manner, it is assumed that further medically necessary care is deemed authorized by the medical group, and payment for such care may not be retrospectively denied.
5. If there is a disagreement between the medical group and the physician, hospital, facility or other healthcare professional regarding the need for further care, the medical group may assume responsibility for the Members care as follows:
    a. The medical group may take over the Members care within a reasonable amount of time.
    b. The medical group can assume responsibility and arrange for the transfer of the Member once a contracted hospital has agreed to accept the transfer.

Hospital Emergency Services Reduction
Hospitals reducing emergency care services must give ninety day (90), prior notice to specific entities (e.g., state and local governments, contracted health plans) and the public. Anthem must give notice to affected enrollees but may require medical groups to provide notice.

The notice must include a list of alternative hospitals that provide emergency services and must be made within 30 days of Anthem receiving notice from the hospital.

Out-Of-Area Emergency Services
Out-of-area emergency services are defined as emergency services that are rendered to a Member as defined in the Provider Agreement from the medical offices of the medical group or the Primary Care Physician to which the Member is assigned.

Out-of-area emergency services also include out-of-area urgent care services, which are defined in the Provider Agreement as “services needed to prevent serious deterioration of a Members health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the service area.”

1. Members who are admitted to a hospital out of their service area must contact Anthem HMO Ops Utilization Management Department within 48 hours of admission, unless extraordinary circumstances* prevent such notification.
2. Approval is determined by Anthem Medical Management staff, after retrospective review of the clinical record.

If extraordinary circumstances are present during an emergency, or when a Member requires urgent care, the Member must notify Anthem as soon as reasonably possible following initial treatment for that condition, so that Anthem can provide case management.

*Extraordinary circumstances include the following situations:

1. If a natural disaster prevents normal channels of communication from being open.
2. If the health plan is operating in a business continuity mode with limited operations intact.
3. If the Member presents to the hospital without identification and/or insurance; or
4. Identity cannot be verified and, therefore, the hospital cannot check benefits or eligibility and follow normal notification procedures.

Health Insurance Portability and Accountability Act (HIPAA)

The Health Insurance Portability and Accountability Act (HIPAA) mandates standards for Electronic Data Interchange (EDI) transactions and code sets. It establishes uniform healthcare identifiers for healthcare professionals, health plans and employers. It also addresses privacy and security issues.

For updates regarding HIPAA, including the HIPAA Readiness Disclosure Statement, refer to Professional Network Update, our newsletter for the HMO network and physicians. Below are our Member HIPAA rights and responsibilities, and confidentiality statement.

Confidentiality
The Provider Agreement requires medical groups to have procedures to protect the confidentiality of Member medical records. These procedures must comply with applicable legal and regulatory requirements, such as HIPAA and California state law, recognized standards of professional practice and generally accepted procedures followed by HMOs. Anthem’s Notice of **Privacy Practices** is provided to our Members and must be adhered to by our medical groups.

Medical Group Requirements for Confidentiality and Accuracy of Enrollee Records
The medical group must have policies and procedures addressing a Members right to have timely access to all their medical records.

Personal Information: Confidentiality of Social Security Number Background
California Civil Code 1798.85 limits the use and disclosure of individual Social Security numbers. It is intended to provide additional protection against identity theft by limiting the use of an individual’s Social Security number.

This law is not limited to the healthcare industry but applies to all persons or entities that use Social Security numbers to identify an individual. All federal, state and local agencies are exempt.

The intent of the law is to protect California residents. Consequently, all persons or entities that communicate with individuals by U.S. mail or via the Internet, and use or disclose an individual's Social Security number, may need to comply with the law by the relevant effective dates for its California population.

The law does not apply to individuals who travel to California but reside in another State. In addition, the law does not prevent the collection, use, or retention of Social Security numbers as required by state or federal law. It also does not prevent the use of Social Security numbers for internal verification or administrative purposes, as long as the use does not result in the public display or disclosure of the Social Security number as outlined in the SB168 restrictions.

Restrictions
California Civil Code 1798.85 prohibits persons or entities from engaging in the following activities:

1. Publicly posting or displaying, in any manner, an individual's Social Security number.
2. Printing an individual's Social Security number on any card required for the individual to access products or services provided by the person or entity (the ID card requirement).
3. Requiring an individual to transmit their Social Security number over the Internet, unless the connection is secure, or the Social Security number is encrypted.
4. Requiring an individual to use their Social Security number to access a website, unless a password, unique personal identification number or other authentication device is also required.
5. Printing an individual's Social Security number on any materials that are mailed to the individual, unless state or federal law requires the inclusion of the Social Security number on the document to be mailed; however, applications and forms sent by mail may include Social Security numbers.

Healthcare Provider Compliance
Since healthcare Providers are unable to determine whether policies are existing or new, and have no knowledge of group renewal dates, they are encouraged to discontinue all SSN disclosures to ensure compliance.

The above is being provided for informational purposes and should not be considered legal advice or relied on as such. All healthcare entities should review the statute in order to gain a full understanding of, and to ensure compliance with the law.

Disclosure of Psychotherapy Notes
HIPAA allows the exchange of information between covered entities for the purposes of treatment, payment and healthcare operations. This exchange refers to general medical records and not psychotherapy notes. Psychotherapy notes are notes recorded (in any medium) by a healthcare Provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record.

Psychotherapy notes DO NOT include medication or prescription information or monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests,

or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

A physician or healthcare professional is prohibited from releasing a patient's psychotherapy notes unless certain requirements can be met. A requesting agent must submit a written request to the healthcare professional and a notice to the patient. The written request will include:

1. A description of the specific information requested and a description of its intended use.
2. The length of time the information will be needed.
3. A statement indicating the information will not be used for a purpose other than its intended use.

A statement indicating the information will not be retained beyond the specified time and that the information will be destroyed or returned to the healthcare professional.

Requests for Disclosure of Medical Information
The Act also requires that a person or entity seeking to obtain medical information must obtain authorization from the patient. The Act further prohibits plan contractors, corporations, or their subsidiaries and affiliates from intentionally sharing, selling or using any medical information for any purpose not necessary to provide healthcare services to the Member.

California's Healthcare Decisions Law (Advance Healthcare Directive)

Effective July 1, 2000, the California Healthcare Decisions Law consolidated California's previous advance directive laws to make it easier for individuals to make their preferences known through written and oral communication.

What does this new advance healthcare directive (AHCD) DO?
It appoints an attorney-in-fact (the person designated as a power of attorney to act on behalf of another is called an attorney-in-fact) for healthcare and/or provides instructions for future healthcare decisions. The AHCD can be used to indicate healthcare treatment preferences, such as management of the dying process and personal values about quality of life.

What is needed to complete a valid AHCD?
It is valid if it:

- Is completed by a competent person over the age of 18.
- Includes the person's name, signature and the date executed.
- Is acknowledged by a notary public or signed by two witnesses.

What do healthcare professionals need to know about an AHCD?

- The AHCD is assumed valid unless there is substantial evidence to the contrary.
- It becomes effective only if the person becomes incapable of making healthcare decisions for any reason (unless the directive stipulates otherwise).
- It can direct that the attorney-in-fact's authority is to take place immediately, even though the person retains decision-making capacity.
- It can state who is not to make healthcare decisions for the person.

- Copies of an AHCD have the same authority as the original.
- A person is not required to complete an AHCD as a pre-condition for admission to a hospital or nursing facility, or for the provision of healthcare.

What is the role of the power of attorney for healthcare?
With a few exceptions, the attorney-in-fact appointed by a power of attorney for healthcare has legal authority in all healthcare matters, unless limitations are stipulated. The attorney-in-fact may:

- Select or discharge physicians, other healthcare professionals or hospitals.
- Accept or refuse medical treatments.
- Receive information on the person's condition, view the medical record and authorize release of the medical record when needed (a link to the Member Authorization and Patient Consent to Exchange Information Forms are provided below):
  - **Member Authorization Form**
  - **Patient Consent to Exchange Information Form**
- Consent to tissue and organ donation, authorize an autopsy, and arrange for disposition of the remains after death.
- Not assume responsibility for medical bills.

Can the person make an oral advance directive?
Yes, with certain restrictions, a person may verbally designate a surrogate to make healthcare decisions by personally informing the supervising physician, hospital or other healthcare professional. This appointment is effective only during the course of treatment, illness or stay in the healthcare institution. A verbal surrogate designation replaces a previous written directive.

What is the healthcare professionals duty?

- A hospital, physician, or healthcare professional must comply with a patient's advance directive or instructions from an attorney-in-fact or surrogate to the same extent as if the patient had made the decision.
- The hospital, physician or healthcare professional must document in the healthcare record all pertinent information about the existence or revocation of an Advance Healthcare Directive (AHCD) or any spoken communication about preferences.
- The primary physician who determines (or is informed of a determination) that a patient lacks capacity or has recovered capacity must record it in the healthcare record.
- Before implementing a healthcare decision for a patient, the hospital, physician, or healthcare professional must inform the patient of the decision and the identity of the person who made it. The patient and attorney-in-fact must be informed immediately of such a decision.

Note: If the hospital, physician or healthcare professional declines to comply with an AHCD or an attorney-in-fact's decision, all reasonable efforts to assist in transferring the patient to another hospital, physician, or healthcare professional must be undertaken and care must be provided to the patient until the transfer can be accomplished.

Can an AHCD be revoked?
Yes. A person having capacity may revoke all or part of the AHCD at any time. The withdrawal must be clearly documented by the physician, hospital or healthcare professional.

- The designation of the attorney-in-fact may be revoked only in writing, or by personally informing the hospital, physician or healthcare professional.
- Healthcare instructions can be revoked in any manner that communicates the intent to revoke.

What if the person does not have an AHCD?
If a person lacks the capacity to make decisions, the healthcare team should turn to the most appropriate decision maker from close family or friends. This should be someone who has a close, caring relationship with the person, is aware of the person's values and beliefs, and is willing and able to make the needed decisions.

Healthcare Decision Definitions

Capacity
A patient's ability to understand the nature and consequences of proposed healthcare, including its significant benefits, risks, and alternatives and to make and communicate a decision.

Healthcare Decision
A decision made by a patient or the patient's attorney-in-fact, conservator or surrogate, regarding the patient's healthcare, including:

- Selecting and discharging physicians, hospitals and healthcare professionals.
- Approval or disapproval of diagnostic tests, surgical procedures and medication programs.
- Directions to provide, withhold or withdraw artificial nutrition, hydration, and all other forms of healthcare, including cardiopulmonary resuscitation.

Primary Care Physician
A physician designated by a patient, or the patient's attorney-in-fact, to have primary responsibility for the patient's healthcare or, if the primary physician is not available, the physician who undertakes that responsibility.

Text of Law
To obtain a copy of AB 891 (Chapter 658, Statutes of 1999) codified at Probate Code, Sections 4600 – 4805, visit **California Legislative Information**.

Advance Healthcare Directive Forms
California Hospital Association (CHA) Consent Manual 2010 contains a copy of a suggested form in both English and Spanish. Manuals can be ordered by calling the phone number or visiting the website provided in *Section 2, Quick References,* under *California Hospital Association*.
Click on this link: **Contact Information**

CMA has developed an Advance Healthcare Directive Kit, which includes a new form. To order, call CMA Publications at the phone number or by visiting the website address provided in *Section 2, Quick References,* under *California Medical Association*.
Click on this link: **Contact Information**

Partnership for Caring has state-specific forms that are available from the National Hospice and Palliative Care Organization (NHPCO) website at **NHPCO**.

Language Assistance Program (LAP)

Introduction

Effective January 1, 2009, Anthem and other California healthcare service plans regulated by the DMHC were required to implement a Language Assistance Program (LAP) to provide language assistance services to their Limited English Proficient (LEP) Members. In addition, insurers licensed by the CDI were required to comply with similar regulations effective April 1, 2009. Further, on January 1, 2012, Anthem and other healthcare service plans were required by Federal Regulators to implement a LAP, which was mandated by the Patient Protection and Affordable Care Act (PPACA). Due to previous State legislation, California health service plans regulated by the DMHC and CDI already had LAPs in place.

Anthem provides services to hearing impaired Members even though SB-853 did not specifically address American Sign Language. Services for hearing impaired enrollees are offered under the American Disabilities Act.

At Anthem, we believe in the strength and value of cultural diversity. We realize that communication with physicians and other healthcare professionals is paramount to ensuring optimum health and wellness.

To facilitate communication, we offer interpretation services to eligible Members at no cost. In addition, documents are provided to Members in languages required by language assistance regulations.

Interpreter Services are coordinated by Anthem or its delegated network provider or other delegated entity with scheduled appointments for healthcare services in a manner that ensures the provision of interpreter services at the time of the appointment without imposing delay on the scheduling of the appointment. Anthem requires providers and provider office staff to document members' request, acceptance, or refusal of interpreter services in the medical record.

Objectives

The objectives of the LAP are to:

- Identify the cultural diversity of the individuals covered by Anthem.
- Explain what is meant by sensitivity to cultural differences.
- Describe the LAP services available.
- Provide guidelines for working effectively with LEP individuals.
- Provide essential tips for working effectively with telephone interpreters.

Threshold Languages

The threshold languages for Anthem are English, Spanish, Chinese (traditional), Korean, Tagalog, and Vietnamese. In addition to the threshold languages, Anthem notifies members and the public of the availability in a timely manner of free language assistance services in the top 15 languages spoken by LEP individuals in California as determined by the State Department of Health Care Services (DHCS).

Navajo is considered a threshold language under the Patient Protection and Affordable Care Act. If you need assistance in one of the languages listed below to understand this document you may request it, free of charge, by calling customer service at the number on your identification card or in your enrollment booklet.

- For Members with addresses in California who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – CA must include English and the following two threshold languages: Spanish and Chinese (traditional)

- For Members with addresses in Alaska who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – AK must include English and the following two threshold languages: Spanish and Tagalog
- For Members with addresses in Arizona, New Mexico or Utah who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – AZ/NM/UT must include English and the following two threshold languages: Spanish and Navajo

Anthem LAP is designed to meet the growing needs of California's diverse population. Anthem is responsible for continually identifying the languages spoken by the individuals for whom health benefits are provided; as well as identifying, tracking, and reporting the written and spoken language preference of each Member.

Anthem Language Assistance Program Services
The following services are offered to Members, free of charge:

Face-To-Face Interpreters, Including Sign Language
Members, physicians, and other healthcare professionals may call the Customer Service telephone number located on the patient's health plan identification card, or the 24/7 Nurse Line after hours, to schedule face-to- face interpretive services during business hours. Every effort should be made to schedule face-to-face interpreters Seventy-Two (72) business hours in advance of appointment, and 24 business hours are required to cancel interpreter. Contact information is provided in *Section 2, Quick References*, under *Language Assistance Program*. Click on this link: **Contact Information**

TTY and Relay Services for a Member With Hearing or Speech Loss
Members may call 711, the national relay number or the relay service of their choice and have the relay operator contact Anthem's Member Service telephone number, which is located on the Members identification card.

Once connected, and if requested, the Anthem representative will coordinate with the appropriate area to schedule an on-site interpreter for the Member (also described above). TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. When communicating with the deaf by telephone, physicians and other healthcare professionals can contact Anthem directly to set up interpreter services on behalf of the Member by contacting Anthem's Provider Care Department at the Customer Service number on the back of the Member ID Card.

Telephonic Interpreter Services Provided at All Points of Contact
Professional interpreters are native or near native speakers who are proficient in healthcare terminology and have been evaluated on a standardized assessment tool. Professional interpreters receive training regarding Health Insurance Portability and Accountability Act (HIPAA) and ethical standards. Points of contact include administrative, healthcare, and related services. Anthem interpretation vendors are contracted to have professional interpreters available in all languages within ten (10) minutes of request.

Physicians and other healthcare professionals are instructed to have their Anthem patient call the Customer Service telephone number located on their health plan identification card to request an interpreter.

Alternatively, Providers may call Anthem's Provider Care Department at the **Customer Service number on the back of the Members ID card** and request to speak with an interpreter. Physicians and other healthcare professionals must document the use or refusal of professional interpreters by their patients.

Vital written materials are provided in six threshold languages:
English, Spanish, Chinese, Vietnamese, Korean, and Tagalog. Vital written documents translated prospectively include enrollment, eligibility and Membership information, Explanation of Benefits (EOB), and notices of language assistance. Members indicate their preferred written language to receive prospectively translated materials.

Non-Standard Written Materials Are Translated Into A Threshold Language Upon Request
Materials that are Member-specific (e.g., denial, delay or claims letters) are sent in English with the offer of translation when requested. Translated materials are sent to the Member no later than 21 days from the request date. To ensure timely translation of materials, physicians and other healthcare professionals should encourage their patients to contact Anthem at the Language Assistance Program phone number provided in *Section 2, Quick References*, under *Language Assistance Program*.
Click on this link: **Contact Information** to request translated materials.

Alternately, physicians and other healthcare professionals can call Anthem's Provider Care Department at the Customer Service number on the back of the Member ID Card.

When contacted by a contracted Provider with a Member requesting translation of documents, Anthem policy is to refer the Member to Customer Service, who can request a translation of documents through the Translation Correspondence Unit. The Customer Service telephone number is located on the back of the Members ID card.

Approved Health Industry Collaboration Effort (HICE) Documents, including the Cultural and Linguistics Provider Tool Kit are available at **ICEForHealth.org**.

Telephone Interactions
For successful interactions between healthcare professionals and LEP Members, it is important to:

- Notify LEP Members of the services available.
- If the LEP Member does not request interpreter services, offer the service during the healthcare visit or contact.
- If a Member has not notified Anthem of their preferred spoken or written language, they are still entitled to language assistance services.
- If a Member brings a family Member or friend to their healthcare visit and requests to use their family Member or friend as an interpreter, offer the use of a professional interpreter. If the Member refuses the offer of the professional interpreter, and the Members decision to use the family Member or friend as the interpreter must be documented in the patient record.
- Anthem strongly discourages the use of a minor as an interpreter. However, a minor may be used in the event of an emergency if the following criteria are met:
    a. The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation and
    b. The Member is fully informed in their primary primary/preferred spoken language that a qualified interpreter is available at no charge to them. If the Member refuses the offer of the qualified interpreter, the Members decision to use the minor as the interpreter must be documented in the patient record.
- Speak slowly, not loudly.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.

- Use open-ended questions to assess for understanding.
- If the Member refused interpreter services and is not demonstrating a full understanding, offer interpreter services again.
- If in-person, monitor non-verbal cues, such as facial expressions, positioning and body language. These may indicate understanding or confusion.

Tips for Working with Telephonic Interpreters
Telephonic interpreter services allow for immediate contact with a professional interpreter. Here are some strategies to optimize communication:

- If possible, speak to the interpreter privately before the contact, providing relevant information regarding the Member and the important information to convey.
- Interpreters are not allowed to rephrase or clarify. Encourage the interpreter to request clarification or to redirect explanations as needed.
- Direct the conversation to the Member, not the interpreter.
- Use short sentences limited to a single concept if possible.
- Allow adequate time for the interpreter to convey the information in the Members language.
- Avoid medical jargon or technical explanations unless the Member requests them.
- Avoid interrupting the interpreter.
- If the Members non-verbal cues indicate confusion, ask the Member to summarize or restate what has been communicated.

Information Available on DMHC's Website

Informational notices explaining how Members may contact their health services plan, file a complaint with their health services plan, obtain assistance from the DMHC, and seek an independent medical review are available in specific non-English languages through the DMHC's website.

Representatives from the DMHC are available by telephone at the phone number provided in *Section 2, Quick References*, under *California Department of Managed Healthcare*.
Click on this link: **Contact Information**

Alternatively, the notices and translations can be obtained online for downloading and printing from the website address provided in *Section 2, Quick References*, under *California Department of Managed Healthcare*. Hard copies can be requested by submitting a written request to the street address provided.
Click on this link: **Contact Information**

6 | General Benefits

This section explains the method by which Anthem Blue Cross (Anthem) HMO plan benefits are to be administered.

Covered Benefits Provision

When an individual seeks medical attention, verification of the Members eligibility status is required. Under the Eligibility Guarantee Program, Anthem will assume liability for services only when eligibility was verified prior to services being rendered, and the Member is later determined to be ineligible.

Determining Covered Benefits

After eligibility is established, the Member should complete all the forms required by the medical group. All treatment must be provided in accordance with the Members EOC.

The Anthem HMO plan code, which is listed on the *Eligibility Report* and the Members ID card, determines the benefits to which the Member is entitled. The Member is liable for paying any non-covered medical services subject to the terms and conditions below. The only charges for which a Member may be liable and billed by their assigned medical group are the following:

Member Cost Share Responsibility (Copayments, deductibles and/or coinsurance) is based on the medical groups allowed amount for the capitated services and are payable directly to the medical group under the terms of the Members EOC. Member responsibility cannot exceed a medical group's cost of providing the service.

Services not covered under the Members EOC, including services denied based on medical necessity, subject to prior notification to the Member and written agreement (waiver letter) by the Member to accept financial responsibility for the non-Covered Services.

The waiver form must be separate from an admission form, signed prior to rendering services and must include an estimate of the cost of services. If the medical group chooses to use their own version of the waiver form, it must meet all regulatory requirements. Invalid waivers will result in Provider financial responsibility for non- covered services and the Member may not be billed.

To ensure your form meets regulatory requirements, review and pre-approval may be obtained by sending a copy of your form for review to Provider Experience at **Contact Us**.

Link: **Patient Responsibility Agreement – Waiver Form.** Type **Member Responsibility Agreement** in the **Search Anthem.com bar**. In the left margin, under **Narrow your results**, choose **Providers**.

Member Cost Share Collection
Member deductibles, copayments, and coinsurance vary by plan. Check the **Benefit Information Report** information, in this section for more details on how to obtain this benefit information.

Member responsibility cannot exceed a medical group's cost of providing the service.

The medical group must advise Members of their cost share responsibility prior to receiving service. The copayment is due regardless of which Provider (e.g., MDs, Pas, RNs etc.) of the medical group treats the Member.

Cost share for services should be collected by the medical group at the time services are rendered.

However, if collection is not possible, the Member may be billed after services are rendered. Cost share collection for missed appointments is at the discretion of the medical group.

Maximum Out-of-Pocket (MOOP)
SB368, which amended Section 1367.0061 of the Health and Safety Code, requires a health plan or health insurer to provide an enrollee or insured with their accrual balance toward their annual deductible and annual out-of-pocket maximum during any month in which benefits were used; permits an enrollee or insured to request their most up-to-date accrual balance toward their annual deductible and their annual out-of-pocket maximum from their health plan or insurer at any time; and requires accrual updates to be mailed unless the enrollee or insured opts out.

If insurer/plan delegates claims payment functions to a contracted entity (i. e., a medical group (MG) or independent practice association (IPA)), the delegated entity must comply with the requirements of this section. Participating medical groups must comply with this provision.

Anthem limits the Member cost share responsibility for copayments, deductibles and coinsurance an Anthem HMO Member must pay during a calendar year. This is called the “maximum out of pocket” (MOOP) expense for a Member.

MOOP liabilities are listed in the Benefit Information Report, referenced earlier in this section of the Manual.

Once a Member and/or the Members family has reached their identified MOOP, no further cost shares are required for Covered Services, for the remainder of the year.

Once a Member has satisfied their MOOP for a calendar year, they will receive written notification from Anthem. The medical group will also receive a letter stating that the Member has satisfied their liability. The medical group is responsible for reimbursing the Member for amounts that are over their MOOP liability for services. The Member will receive an over-applied letter directing them to their medical group for reimbursement of amounts in excess of their MOOP.

Benefit Limitations and Exclusions
To verify general limitations and exclusions for benefits and services, medical groups should use Availity at the website address provided in *Section 2, Quick References,* under *Availity Essentials Client Services*. *Click on this link:* **Contact Information.**

Additionally, medical groups can also verify benefit limitations and exclusions by calling a Customer Service Representative at the telephone number listed on the Members ID card.

Choosing A Medical Group And Primary Care Physician
When the subscriber enrolls, they must select a medical group for themselves and all dependents.

If the medical group is structured as an Independent Practice Association (IPA), the Member must choose a Primary Care Physician (PCP). The PCPs responsibility is to diagnose and treat most illnesses and coordinate all healthcare needs. Coordinating care includes referring Members to specialists when necessary.

Members are urged to develop a relationship with the PCP and follow their advice. For children, a Pediatrician may be selected as the PCP.

Members do not need prior authorization from Anthem or from any other person (including a PCP) to access care from an OB/GYN professional.

Members Changing Medical Groups
Anthem allows Members to change medical groups, provided the Member lives, works or attends school within the designated service area outlined in the Members EOC, of the new medical group, and is not undergoing medical treatment.

Exceptions:

Open Enrollment
Members may change their medical group during open enrollment, even if they are undergoing medical treatment.

Change of Address
Defined as a change of primary residence. A Member may change medical groups when the new primary residence is outside the service area of the Members current medical group, regardless of current medical treatment.

Health Benefit Plan Terms
When a Members health benefit plan expressly permits them to change medical groups.

Quality of Care
If the Member is dissatisfied with the quality of care from their medical group, they should contact Customer Service. The quality-of-care complaint will be filed with the G&A department prior to an authorization to change medical groups.

Referral Services Authorization

Professional Services
Anthem HMO Benefit Agreements offer a comprehensive range of medical services, some of which will require the use of various medical specialties. At times, medical groups use outside physicians and healthcare professionals to provide specialty care. The medical group is responsible for contracting with referral physicians, as well as making all necessary arrangements for providing services performed outside of the medical group.

Such contracts must ensure that the referral physician looks only to the medical group, and not to Anthem or the Member, for payment.

HMO Professional Services
It is the responsibility of the medical group to monitor quality of care, as well as costs associated with outside referrals. Outside referral, physicians and other healthcare professionals must be paid within 45 working days following the medical group's receipt of a clean, undisputed claim.

In the event a referral physician or other healthcare professional is not reimbursed for authorized referral services within 45 working days, Anthem reserves the right to pay the claim and deduct those amounts paid, from any payments to the medical group, plus an administrative charge, as outlined in the Provider Agreement.

Accessing Specialists Through *ReadyAccess*
ReadyAccess is comprised of two components that provide different means of accessing specialists: *Speedy Referral* and *Direct Access.*

Speedy Referral
This program allows the Members PCP to authorize and issue a speedy referral to certain specialties. The specialties are:

- Allergy
- Cardiology
- Dermatology
- Endocrinology
- Ear, Nose and Throat
- Gastroenterology
- General Surgery
- Hematology
- Neurology
- Oncology
- Ophthalmology
- Orthopedic Surgery
- Podiatry
- Routine Laboratory
- Routine X-ray
- Urology

Direct Access
This program allows Members to self-refer to five (5) specialties within a medical group who is participating in the program. The Member does not need to obtain a referral from a PCP, and no other type of prior authorization from the Members assigned medical group is required to visit the specialist.

Members receive notification describing *Direct Access* as "Members can self-refer to the following specialties for medically necessary and appropriate services that can be performed in the specialist's office."

The five specialties covered by *Direct Access* are:

- Allergy
- Dermatology
- Ear, Nose and Throat (ENT)
- Obstetrics/Gynecology
- Reproductive and Sexual Health Services

Services not included in *Direct Access* should be provided in accordance with the medical group's existing referral, authorization, and treatment protocols and procedures, and Member benefits. In some cases, this may mean that the specialist will refer the Member back to the Members PCP or the medical group for further or subsequent treatment. The medical group is responsible for monitoring the services provided by the specialist.

Professional Referrals

When specialty care is required, the PCP may make referrals to other physicians or specialists. Dermatologists, General Surgeons, Allergists and Physical Therapists are examples of other professionals.

A Member must generally have a referral from the Members PCP to receive coverage for professional services.

However, routine and preventive women's health services (e.g., mammography screening services, pap smears, pelvic and breast exams) do not need a referral. Contracted medical groups must offer female Members the option of receiving these preventive services at least once a year from an in-network OB/GYN, if the Member so chooses.

Before performing extensive referral services, the servicing physician must be aware that authorization is necessary for payment by the medical group. The medical group may wish to include this information on the referral form and/or other communication with the servicing physician.

Some medical groups have found it useful to have the PCP authorize only an initial evaluation or consultation. A treatment plan can be determined and authorized after the results from the evaluation are provided.

In addition, the medical group communicates to both the Member and referral healthcare professional that follow-up visits, unless authorized, are not reimbursed. It is the medical group's responsibility to inform the Member and servicing physician of all steps in the referral process, including any limitations to authorized Member services.

Under the terms of the Anthem Provider Agreement*, and the Knox Keene Act, neither medical groups nor referral physicians or other healthcare professionals may charge a Member for authorized services. If five (5) or more instances occur where any physician or other healthcare professional associated with a medical group bills a Member, Anthem will suspend assigning new Members to the medical group until the medical group has rectified the problem to Anthem's satisfaction. *Check your contract for verification and details.

The medical group or the Member should call to schedule the Members appointment with the referral specialist. When the appointment is scheduled, the medical group completes the written referral process, and a copy of the form is saved in the Members chart.

It is important for the Provider and medical group to verify that the referral services are covered under the Members plan, because once a referral is given, it cannot be withdrawn, and the charges must be paid. Use the following guidelines when scheduling referral services:

1. For specialties other than those covered by ReadyAccess, referral services must be authorized by the medical group or medical group's physician, in order to receive payment. If the services are not authorized, the Member is not financially liable, unless a valid waiver is signed.
2. Notification of an adverse decision is provided to the Member and the attending physician in a manner that is most appropriate to the urgency of the clinical situation.
3. Use the Behavioral Health Consultation Request form to obtain the Members consent for the mental health specialist to communicate with the PCP.

4. Denials of any service must be given by a qualified, licensed medical professional with the clinical expertise necessary to understand and apply the criteria used to evaluate medical necessity.
5. Denials based on clinical inappropriateness or lack of medical necessity must be made after the California licensed healthcare professional makes a good faith attempt to collect additional clinical data necessary to complete the review process.
6. For non-expedited referrals to specialists or healthcare facilities, the medical group reviews and issues requests for referral authorization or denial within 5 calendar days of receipt of such requests or admission to the hospital.
7. The health professional looks only to the medical group for payment of medical services and will not bill the Member except for applicable copayments or non-covered medical services, for which the Member has agreed to in pay, in writing, with a valid waiver.

Specialist Standing/Extended Referrals
PCPs must be able to request:

- Standing referrals for Members with chronic conditions, including human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS) requiring ongoing specialty care over a prolonged period of time.
- Extended access to a specialist for a Member who has a life-threatening, degenerative or disabling condition that requires primary care coordination by a specialist; the specialist is designated to serve as the enrollee's care coordinator except for minor problems unrelated to the major specialty-directed condition.
- A Member with HIV or AIDS must be provided with an extended referral to maximize their access to a practitioner who has expertise in treating their condition, which requires ongoing monitoring of the Members adherence to the regimen and who meets California Health and Safety Code criteria for being an HIV specialist.

The medical group must have criteria in place for the identification of an appropriate specialist and must provide a listing to Members.

Referral Process
The need for specialist care is determined by the Members PCP, the specialist and the plan Medical Director (or designee). Treatment plans may limit the number of specialist visits or the length of time for which the visits are authorized and may require the specialist to provide regular reports to the PCP.

Upon receiving a standing referral request, the medical group must approve or decline the referral within three (3) business days. If authorized, when the treatment plan is received, the actual referral must be made within four (4) business days. The PCP must refer to an out-of-network specialist if one is not available within the medical group who can provide appropriate specialty care to the Member.

After receiving a standing referral approval, the specialist is authorized to perform healthcare services within the specialist's area of expertise, in the same manner as the PCP.

Obstetrics/Gynecology (OB/GYN) And Pediatricians
Members must have direct access to participating OB/GYNs, and Family Practice physicians and surgeons designated as providing OB/GYN services and Pediatricians within their medical group; prior approval from the PCP is not required.

Note: Direct access to OB/GYN and Pediatricians applies to all medical groups and is independent of the Direct Access program.

Vision Examinations

The medical group should develop a simple office screening procedure for determining the medical necessity of a vision examination, and the physician ordering the vision exam should use the specified procedures of the Members medical group.

The screening should consist of routine vision testing, including testing for any deviation from normal vision. If potential problems are detected, a referral should be issued for examinations for refractions and diagnosing or correcting vision, and prescriptions for corrective lenses or fitting contact lenses (including after cataract surgery).

The medical group should determine whether the Member has a supplemental vision plan that provides additional benefits. If so, it should be noted on the referral. Prior authorization is not required for supplemental vision, dental or hearing. Remind Members who do not have supplemental riders that the charges for purchased frames and lenses (including a contact lens fitting) are their financial responsibility and **will not be** reimbursed.

Hearing Examinations

Hearing examinations should include a physician's examination of the ears and audiometric screening procedures. If an auditory defect is suspected, arrangements to be evaluated by an appropriate specialist should be scheduled.

Services Managed by the Medical Group

Utilization Management Decision-Making Criteria
Anthem provides its criteria for determining medical necessity on our website at the address provided in *Section 2, Quick References,* under *Anthem HMO Co-Management Department.*
Click on this link: **Contact Information**

From the Provider Home page for California, under **Provider Resources** in the left-hand margin, select **Policies, Guidelines & Manuals.** Scroll down to the middle of the page and select **"View Medical Policies & UM Guidelines**."

Follow-Up and Self-Care
Procedures should be in place to ensure Members are informed of specific healthcare needs that require follow-up care. Medical groups are required to address barriers to Member compliance with prescribed treatment regimes. Members should receive, as appropriate, training in self-care and other measures to promote their own health.

☏ **911/Emergency Care**
Emergency services are services provided in connection with the initial treatment of a medical emergency.

If Members need emergency services, they should get the medical care they need immediately. Members should use this service by calling the ☏ **911** emergency response system. If Members want, they may also call their PCP and follow their instructions.

The PCP or medical group may:

- Ask the Member to come into their office
- Refer the Member to a hospital or emergency room
- Call an ambulance for the Member
- Provide the Member with the name of another doctor or medical group and direct him or her to go there
- Tell the Member to call the ☎ **911** emergency response system. Once the Member is stabilized, their PCP must authorize additional care
- Members should ask the hospital or emergency room doctor to call their PCP, who will authorize medically necessary care or will take over the management of their healthcare needs. The Member may need to provide copayment for emergency room services
- A Member should be directed to call the telephone number on their Anthem ID card with any questions

Remember: A Members PCP or medical group must authorize the care they receive once the Member is stabilized.

An emergency means a sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, sudden and unexpected severe pain) such that the absence of immediate medical attention could reasonably be expected to result in any of the following conditions:

- Placing the health of the individual or another person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- Serious impairment to bodily functions, or
- Serious dysfunction of any bodily organ or part.

Emergency includes being in active labor when there is inadequate time for a safe transfer to another hospital prior to delivery, or when such a transfer would pose a threat to the health and safety of the Member or unborn child.

Therefore, Anthem expects all HMO practitioners to instruct their after-hours answering service staff to direct callers who believe they are experiencing an emergency to dial ☎ **911** or go directly to the emergency room. If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted. Answering machine instructions must also direct the Member to call ☎ **911** or go to the emergency room if the caller believes they are experiencing an emergency.

Emergency Services Denial
Emergency services may not be denied for lack of prior authorization, or because of a Members failure to notify the medical group in advance, or within a certain time after care is received.

Other Services

Workers' Compensation
Workers' Compensation coverage is founded on the philosophy that industry should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to

who is at fault when an injury occurs during the course of employment. Anthem HMO plans exclude coverage for work- related conditions. However, there are many cases in which an industrial injury is disputed and the employer refuses to accept liability for the injury. When cases of this type occur, Anthem HMO will provide coverage, subject to the following guidelines:

1. Once a work-related injury or illness is accepted by an employer, Anthem denies claims for that illness or injury.
2. If Anthem is advised that the employer's Workers Compensation carrier denied payment of the claim, the law requires that health plan benefits be provided. Anthem will pay related claims and will file a lien for reimbursement, if the carrier's decision is appealed.

Medical Group Guidelines
The medical group should question a Member seeking medical treatment when the nature of the illness or injury appears to be work-related. Some employers insist that all Workers Compensation cases be handled through their private Workers Compensation physicians and only when authorized. These employers will not reimburse any other service physician, hospital, facility or other healthcare professional. At no time is the medical group to deny treatment based on the possibility of a Workers Compensation case. However, the medical group should determine whether the Members illness or injury is:

Non-Emergent
Instruct the Member to obtain authorization from the employer before treatment is rendered. The employer contacts their Workers' Compensation carrier. If the Member arrives at the medical group and has an appointment, the medical group must contact the employer.

Emergency (24 hours/7 days a week)
If a Member requires emergency treatment during or after normal business hours, care must be provided to the injured person. Determining Workers' Compensation coverage should be made within the next 72 hours. The medical group will be reimbursed from the Workers' Compensation insurance carrier.

If a Member is covered for Workers' Compensation benefits by a Workers' Compensation carrier, or if a self- insured employer contracting with Anthem seeks services for a work-related illness or injury, the medical group has the following options:

1. Provide such Medically Necessary medical services; or
2. Refer the Member to a healthcare professional that participates in the Medical Provider Network (MPN) that covers the injured worker, who is also contracted with the Anthem Prudent Buyer Network. Not all Anthem Prudent Buyer Network Providers are included in an employer's MPN for Workers' Compensation. The employee, employer, or insurance carrier should know how to access the listing of MPN Providers online. If the medical group elects to treat the Member, the medical group must complete a Doctor's First Report of Injury, as defined in the California Labor Code.

The medical group agrees to accept, as payment in full, compensation for such rendered services, in accordance with the fee schedule set forth in the current Anthem Prudent Buyer Plan Participating Physician Agreement Fee Schedule for the applicable region.

If the Member requires medical services in connection with the work-related illness or injury beyond the treatment provided at the initial visit, the medical group must refer the Member only to a healthcare professional that participates in the Medical Provider Network (MPN) that is also contracted with the

Anthem Prudent Buyer network. If the medical group elects not to treat the Member with a work-related illness or injury, the medical group agrees to refer the Member only to a participating Provider as described above.

Anthem Workers' Compensation Other Payors

For a list of other payors who access the Anthem Network, refer to the "Network Leasing Arrangements Disclosure" document available on the Availity. From the **Home Page**, select **Payer Spaces>Anthem Blue Cross.** Type in **Education and Reference** in the search bar>select **Anthem Blue Cross Education and Reference Center>Administrative Support>**scroll down and select **Network Leasing Arrangements**.

Additional Information
For additional information regarding the obligations of the treating physician for Workers Compensation, visit Anthem's Workers Compensation Managed Care Services (WCMCS) website or call them at the website address or phone number provided in *Section 2, Quick References,* under *Workers' Compensation*. *Click on this link:* **Contact Information,** or you can visit the website of the California Division of Workers' Compensation, which is also provided.

Benefits Extension
Extension of Benefits coverage may be approved for Members who are totally disabled on the day their group Benefit Agreement terminates and there is no succeeding carrier. Benefits Extension coverage is available for 12 months and provides coverage for the Members disabling condition only. Total disability is defined as:

1. ***Subscriber***
   The subscriber, because of illness or injury, is unable to continue to work at their occupation for which they have been trained, educated or is qualified, and is not engaged in any employment or occupation for wage or profit.
2. ***Family Member***
   The family Member is prevented from performing all normal daily activities that are usual for a person of their age and family status.

Benefits Extension Eligibility
If a Member is totally disabled when the group Benefit Agreement terminates and is under a physician's treatment, benefits may continue to be provided for services treating the totally disabling illness or injury. Benefits are not provided for services to treat any other illness, injury or condition. This extension is not available if the Member is covered under another group health plan that provides coverage without limitation for the disabling condition.

If a Member is confined as an inpatient in a Hospital or SNF and is totally disabled, no written disability certification is required as long as the inpatient stay is medically necessary.

1. If a Member is not confined as an inpatient, but wishes to apply for total disability benefits, they must submit a physician's written certification of their total disability. Anthem must receive this certification within 90 days of the date coverage ended under the Agreement. At least once every 90 days, while benefits are extended, Anthem must receive verification of the Members continuing disability.
2. Benefits are provided until one of the following occurs:
   a. The Member is no longer totally disabled.

b. The maximum benefits under the Members certificate are paid.

c. The Member becomes covered under another group health plan that provides coverage without limitation for the disabling Illness or injury.

d. A period of up to 12 consecutive months has passed since the date coverage ended. Initial and continuing treatment rendered in connection with a totally disabling illness, injury or condition that is not authorized by a PCP or medical group is subject to all provisions and requirements governing services provided by self-referral physicians, hospitals or other healthcare professionals.

3. There are two types of certificate language that address a Members eligibility for Extension of Benefits and the conditions for approving Extension of Benefits coverage:

   a. When the certificate language states, “If you are totally disabled and under the treatment of a physician on the day your coverage under this plan ends,” only the Member must terminate their group coverage to be granted Extension of Benefits.

   b. When the certificate language states, “If you are totally disabled and under the treatment of a Physician on the date of discontinuance of the agreement,” the entire group must terminate its group coverage for a Member to be granted Extension of Benefits. If Extension of Benefits approval is related to 1a above, there may be no succeeding carrier.

Benefit Payment
The medical group is paid capitation based on the Members extended coverage plan code. The capitation payment is issued as a manual adjustment for the period covered through the following month. Anthem notifies the medical group in writing when this occurs. The Member’s name does not appear on the eligibility listing.

Non-capitated services for patients eligible for Benefits Extension are covered. Mail non-capitated claims to the Exela Technologies address provided in *Section 2, Quick References,* under *Exela Technologies*. *Click on this link:* **Contact Information**

If pharmacy benefits were part of the Members employer group contract, they continue to be covered under the extension of benefits. Send all prescription claims to Anthem. Include a note identifying the claim as an Extension of Benefits case.

Exclusions
Extension of Benefits does not apply to:

1. Non-group coverage.
2. Services treating any condition, illness or injury other than the disabling condition. Since Extension of Benefits coverage is for the disabling condition only, the same contract exclusions and limitations that were in force when the contract was active remain in force under the Extension of Benefits coverage.

Benefit Information Report
The HMO Benefit Report is available for Large Group benefit plans on **Availity > Payer Spaces > Anthem Blue Cross > Applications>HMO Benefits.** The report is downloadable and presents detailed benefit information on Anthem Blue Cross (Anthem) HMO contract codes in a user-friendly format.

The field descriptions for the Large Group benefit plan reports include:

1. **Report ID.** The Anthem report number.
2. **Run Date/Run Time.** The date and time the report was run.
3. **Title.** The title of the report.
4. **Contract.** The Anthem contract code.
5. **Effective.** The effective dates of the contract. The effective date of “01/01/0000 through 12/31/9999” will usually appear in this field and is used to indicate a contract that is currently active and has not been modified (thus, the “open” date assignment). When a valid beginning date is listed, this indicates the date the modified benefits became effective. A valid end date reflects the date the previous benefits are no longer effective. In most cases, the valid end date appears as the new beginning date of the modified benefits.
6. **Page.** The page number of the report.
7. **Job Name.** An internal Anthem code that identifies the report.
8. **Plan.** When the contract code refers to a custom plan, the name of the employer group that purchased the plan is listed in this field. When the contract code is for a standard plan, an identifier, such as pharmacy benefits (e.g., RX4), appears in this field.
9. **Corp Plan.** This field lists Anthem Plan code assigned to the contract (e.g., C4, MA, and ZB).
10. **Product.** The product category or network the plan belongs to, such as Anthem HMO or Point of Service.
11. **Benefits.** A list of benefits covered under the contract. Only benefits covered are listed. Any benefits not appearing are not covered under the contract.
12. **Network.** Indicates which Anthem network the benefit information is applicable to:

    ALL – Benefits are applicable to all physicians, hospitals or other healthcare professionals, regardless of network affiliation.

    HMO – Benefits are applicable to the Anthem HMO network only.

    NPAR – Benefits are applicable to physicians, hospitals or other healthcare professionals who do not participate in the Anthem PPO network.

    PAR – Benefits are applicable to participating Anthem PPO Physicians, hospitals or other healthcare Professionals.
13. **Value.** If a numeric value is applied to the benefit, it appears in this field. For example, if the skilled nursing Facility (SNF) benefit is limited to 100 days per calendar year, the value “100” appears in this field. This field also uses the values “Y” (yes) or “N” (no) to indicate the confirmation of certain benefit parameters; for example, under the heading of ambulatory surgical centers (ASCs), the “ASC Covered” value is “Y,” indicating that ambulatory surgical benefits are covered. The “ASC Subject to Copay” value is “N,” indicating that there is no copayment required for ASC services.
14. **Format.** This field provides a further description of the numeric value, identifying what the numeric value is counting. For example, the skilled nursing benefit is limited to 100 “days” per calendar year.
15. **Notes.** Any additional comments about the benefits appear in this field.
16. **Page Number**. Indicates the page of the report on which the contract begins.

17. You can use this field to locate any contract code. (This will be especially helpful when looking for information in the large initial report).

For additional information, contact California Contract Support (Provider Experience), at the web address provided in *Section 2, Quick References*, under *CA Contract Support*.
Click on this link: **Contact Information**

Anthem HMO Large Group, Small Group and Individual Plans Authorized Services
This section provides an overview of administering authorized medical services. Refer to the Anthem HMO Benefit Information Report for Large Group plans for specific Member benefit details. Small Group and Individual Member benefits can be obtained via Availity.

The language in your Provider Agreement and the Members EOC take precedence over the information below.

The benefit services are provided only when performed, prescribed or authorized as medically necessary by a physician of the Members assigned medical group. However, services for the treatment of mental or nervous disorders and severe mental disorders may be received directly, without obtaining referral from the primary care physician (PCP). Some services may require Anthem to evaluate and approve treatment in advance. See the Medical Management Program & Policies section of this Provider Manual.

Anthem Preferred HMO (POS)
Anthem Preferred HMO provides Members with limited coverage for selected services from a physician outside the Anthem HMO network of physicians. Anthem Preferred HMO plans allow Members to access services from physicians who are part of the Anthem Blue Cross Preferred Provider Organization Network (PPO).

Some Anthem Preferred HMO plans also allow Members to access services from physicians who are not part of the Anthem PPO network. Under these plans, Members receive a higher benefit if an Anthem PPO Plan Physician is accessed.

Benefits are paid for non-Anthem PPO Physicians only when the Member has a written referral from an Anthem PPO Physician. Referral to non-Anthem PPO Physicians may be made when there is no Anthem PPO physician practicing or providing the required specialty.

Referrals to non-Anthem PPO physicians must be authorized in advance by the Anthem Utilization Review Department.

To determine if a Members contract allows for services of physicians outside of the Anthem PPO Plan network, Providers can access membership and eligibility information through Availity, the Provider Care Department or the automated Interactive (IVR) System. For more information on these options, see the **Quick Reference** section in this Provider Manual.

Anthem HMO physicians are not responsible for services rendered by physicians outside the HMO network. Refer to **Benefit Information Report** for a summary of services Members may access outside the Anthem HMO network of Physicians.

Anthem POS
Anthem Point of Service (POS) Members **may not** use their “opt out” benefits for services provided by their own PCP or a “Direct Access” Provider (affiliated with a Direct Access participating medical group).

“Direct Access” Providers include the following types of specialists:

- Allergy
- Dermatology
- Ear, Nose and Throat (ENT)
- Obstetrics/Gynecology
- Reproductive and Sexual Health Services

POS Members may use their “opt out” benefits to access any other specialist that practices within their medical group (or outside of it).

The Anthem POS Plan is a managed care health plan that combines the comprehensive, cost-saving coverage of a Health Maintenance Organization (HMO) with the flexibility and freedom of choice of a Preferred Provider Organization (PPO).

Anthem POS allows Members to access Anthem PPO network Providers whose negotiated rates offer cost savings. The Members will have deductibles, coinsurance and benefit maximum limits.

Anthem PPO Providers will file claim forms for Members. Anthem POS Members may also access non-Anthem PPO network Providers but will have higher out-of-pocket costs. The Members may have to file their own claim forms to Anthem and pay for services when they receive care.

Anthem POS offers the comprehensive benefits of the Anthem HMO and PPO plans, but some preventive care services are not covered for PPO or out-of-network Providers.

Supplemental Benefits – Vision
For small or large (51 or more employees) groups, Anthem offers Blue View Vision, proprietary vision coverage from ***Anthem Blue Cross Life and Health Insurance Company*****.**

The Blue View Vision network consists of more than 35,000 Providers nationwide, including independent optometrists and ophthalmologists, as well as the following marquee retailers: LensCrafters®, Target Optical®, and most Sears Optical SM and Pearle Vision® locations.

To use the Blue View Benefit, Members choose a Provider in the Blue View Vision network and make an appointment. At the time of service, they present their ID card and pay their eye exam copayment and any balance for non-covered Services. Providers must verify eligibility and handle paperwork submission.

Supplemental Benefits

Anthem contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to provide additional chiropractic and acupuncture benefits to Members whose employer group has this supplemental rider. ASH Plans provides chiropractic only and a chiropractic and acupuncture rider through a statewide chiropractic and acupuncture network. It is the Members choice whether to use the chiropractic and acupuncture benefit through ASH Plans, as described below, or through their medical group.

The benefits covered by ASH Plans are in addition to the benefits covered by Anthem HMO. In order to obtain chiropractic and acupuncture benefits, the Member must first make an appointment with an ASH Plan Chiropractor or Acupuncturist for an initial examination of their condition. Members can obtain a listing of ASH Plan Providers in their area on Anthem’s website at the address provided in *Section 2, Quick References,* under *American Specialty Health*. *Click on this link:* **Contact Information**

Members can locate a Provider by using Provider Finder, contacting their employer's benefits administrator, or calling the American Specialty Health (ASH) number at the phone number provided in *Section 2, Quick References*, under *American Specialty Health*. *Click on this link:* **Contact Information.** Members do not need a referral from their Anthem HMO PCP to see an ASH Plan Provider.

Supplemental Benefits – 24/7 NurseLine
24/7 NurseLine is a program that provides Members with confidential, 24-hour nurse access in order to help them make decisions about their medical care. When Members dial the number listed in their EOC, they are taken through a series of prompts designed to guide them to the most appropriate source of medical information (i.e., an extensive audio tape library, a registered nurse consultant or to their ☏ **911** emergency line).

24/7 NurseLine uses an automated Member assessment system, based on clinical algorithms, which allows the nurse to triage the Member in the manner most appropriate to the Members complaint. These clinical algorithms are reviewed by Physicians and nurses to ensure that they reflect acceptable local standards of care.

Note: 24/7 NurseLine is not available to all HMO Members.

Audio Library
24/7 NurseLine offers Members an extensive audio library with information on hundreds of health topics, including:

- Alcohol and other drugs
- Arthritis
- Cancer
- Children's health
- Contraception and pregnancy
- Dermatology
- Digestive system
- Ear, nose, eyes and throat
- General health information
- Health and blood vessels
- Men's Health
- Mental Health
- Respiratory System
- Sexuality
- Urinary System and Kidneys
- Women's Health

Registered Nurse Consultant
When speaking with a 24/7 NurseLine nurse, the Member is asked a series of questions that are designed to help the nurse direct the Member to the most appropriate level of care for their particular condition:

1. **Emergency Procedures**. The Member is directed to hang up and call ☏ **911**. This recommendation is forwarded to Anthem for entry into the Utilization Management system and

is faxed to the Members medical group.

2. **24/7 NurseLine Physician**. If additional telephone assistance is required, a 24/7 NurseLine physician may be consulted.
3. **Urgent Care**. The Member is instructed to seek medical care within the next two (2) hours. After business hours, the Member is directed to the medical group's urgent care center or emergency room. A record is faxed to the medical group and to Anthem for entry into the Utilization Management system. If the medical group does not have a designated urgent care center or emergency room, the Member is instructed to call their medical group.
4. **Anthem HMO Physician**. The Member is advised to contact their medical group for further assessment.
5. **Earliest Available Appointment**. The Member is instructed to see their physician at the earliest opportunity (not to exceed 24 hours).
6. **Routine Appointment**. The Member is instructed to see their Physician within the next two (2) weeks.
7. **Self-Care**. The Member is provided with self-care instructions and advised to call back if symptoms persist or worsen.

Benefit Reporting

Benefit information is provided to medical groups to assist in managing Anthem HMO products. The Eligibility and Capitation Remittance, Prior Period Adjustment, Activity, Retroactive Contract Adjustments, POS Supplement electronic data files, and other supporting files are available on Availity by the 10th of each month.

Ensure that the Provider data files are downloaded monthly from Availity. The portal currently only stores six months of reports.

Electronic Data Files
Provider Data File Layouts for Capitation File Types are the file layouts that provide start positions of data fields to assist you in analyzing all files. For 'Raw Text ', the Provider data dictionaries include specific column numbers that equal the start position of the data field in the files. 'Raw Text' files can be opened with the Microsoft Note Pad application and imported into Microsoft Excel using the Excel import wizard. Effective January 2021, Commercial Capitation Reports ELG, ADJ, ACT, RET, MOR, and POS will be available in CSV format with headers. MMR Reports and SSB Roster Reports continue to be available in CSV format without headers.

Monthly eligibility and capitation information can be found on four electronic data files:

Eligibility and Capitation Remittance file – Contains prospective capitation and membership detail that meets SB 853, SB 260 and SB 168 reporting requirements.

Prior Period Adjustment file – Contains all financial activity incurred in a prior month(s) and reported in the current month.

Activity file – Contains financial and non-financial activity incurred in a prior month(s) and reported in the current month (this file does not contain dollar values for adjustments).

Retroactive Contract Adjustments file – Contains financial adjustments resulting from implementation of retroactive changes in a medical group's contracted capitation or enrollment protection rates or payments.

POS Supplement file – contains details used to calculate quarterly and annual POS supplement.

MMR (Medical Management Reporting) – The reporting of Medicare Risk Members coming from CMS provides rates, CMS reason codes, premiums, and additional details for Medicare Risk Members. Medicare Risk Members can also be found on the Capitation Eligibility files under HMOMCRSK product on commercial files.

MOR (Monthly Operating Report) – This report includes disease specific grouping codes, CMS Reason codes and other details for Medicare Risk Disease Grouping records.

SB138 HIPAA Weekly Confidential Report – This report is a State mandated report for a Confidential Communication (CC) request under HIPAA (federal law).

Note: Newly enrolled individual plan Members and employer groups that are not processed prior to the capitation run date, and existing employer groups with membership changes that have not been reported prior to the capitation run date will be reflected in the following capitation reporting month.

The electronic data file layouts can be found on Availity. From the Availity Home Page**:**
Select: **Payer Spaces>Anthem Blue Cross>Applications Tab>Provider Online Reporting (POR)**. Select **Organization**, then hit **Submit.** This will open the **Home Page on POR**. Select **Programs tab**>select **A Program**>choose **Reports**.

The File layouts will appear in the **Program Documentation Section** of the page. You will then be able to choose the specific File Layout you need. Note: Your organization's Availity Essentials Administrator needs to grant access to Provider Online Reporting to each user.

Claim Inquiry
Anthem will reconsider rejected or returned claims on the physician's or healthcare professional's request.

Coordination of Benefits
Coordination of Benefits (COB) determines responsibility for paying eligible expenses among insurers providing group coverage to the Member. This ensures that all reasonable expenses for covered services and supplies are paid up to the coverage limits but will not exceed the total expense incurred for those services and supplies.

In order to determine if a Member has other coverage, the medical group should ask about additional health insurance coverage during the Members welcoming interview or on an informational questionnaire administered during the first visit. An update should be done whenever extensive services are provided.

Notify Anthem if the medical group determines that an Anthem HMO Member has additional coverage. If you receive a letter requesting COB information about a Member, and you have information you can share with Anthem, your response will help us with administering the Members claims more efficiently.

When a Member has other health insurance coverage, benefits are coordinated with insurance carriers and health plans. The medical group has the right to recover the value of professional services rendered

to Anthem HMO Members who have other coverage with primary payment responsibility. If the other coverage is secondary, the medical group can coordinate with the other carrier. If a Member is covered under two HMO plans and the medical group is receiving capitation from both plans to cover the Member, waive copayments and deductibles.

Third-Party Liability
The capitated Provider should question a Member for possible third-party liability in all injury cases. Often, the Member will not mention that this liability exists, since they receive complete care from the medical group and may not feel it is necessary to pursue a third-party liability case.

Anthem HMO plans provide that Anthem may recoup benefits for medical care that is received in connection with any illness, injury or condition for which a third party may be liable. In such cases, the medical group provides benefits to the Member, subject to certain limitations.

Anthem will be entitled to collection on its lien, even if the amount recovered by or for the Member (or their estate, parent or legal guardian) or for the account of such third party as compensation for the injury, illness or condition is less than the actual loss suffered by the Member.

Other Financial Arrangements

Financial Statement Audit Requirements
It is the policy of Anthem to take appropriate action in order to limit its exposure to unwarranted financial risks from its business relationships with its delegated medical groups. It begins with screening analysis of the medical group by appropriate Anthem units. This includes the conduct of a financial review by HMO Finance. The review involves tracking the financial performance of the medical group particularly those experiencing adverse financial trends.

Additionally, state rules and regulations require that health plans monitor the financial position of its capitated medical group or delegated risk bearing organizations (RBOs) to ascertain that they demonstrate compliance with the terms of their Provider Agreement with such medical group including financial solvency requirements mandated in ***Title 28, Section 1300.75.4*** of the California Code of Regulations (CCR). They must also meet at all times the financial performance standards or covenants hereunder listed, which is mandated by the Provider Agreement. Our concern is to protect Anthem Members from Provider group insolvency that may result in the interruption of the delivery of healthcare services.

The medical group must furnish the quarterly and annual financial information to Anthem, and other information and documents as may be required by law or Anthem. Click on this link to view DMHC's Financial Audit Requirements: **DMHC's Financial Audit Requirements**.

Pursuant to your Provider Agreement and DMHC's Financial Audit Requirements, each medical group is required to submit audited annual financial statements and DMHC submission copy to Anthem no later than 150 calendar days (5 months) following the end of its fiscal year. The annual financial statements shall be attested by an independent certified public accountant (CPA). The medical group may also be required, if necessary, to submit tax returns, along with the internally prepared financial statements and other related reports.

In addition to the fiscal year-end financial statements, the medical group also agrees to provide Anthem with quarterly financial statements and DMHC submission copy within 45 days after the close of each fiscal quarter, or as often as deemed necessary by Anthem to ensure appropriate monitoring. The financial data enables Anthem to assess the financial status of the medical group and/or its capacity to

fulfill its financial obligations under the Provider Agreement.

Anthem reserves the right to amend at any time the financial audit requirements and financial performance standards herein indicated. Hence, upon its discretion Anthem shall add to, delete from and otherwise modify any part of this section.

Financial Performance Standards
Regulations require the financial statements must be prepared in accordance with generally accepted accounting principles (GAAP regulations) and include a balance sheet, income statement, cash-flow statement and disclosures, schedules deemed necessary by Anthem.

The Monthly, Quarterly and Audited Annual financial statements must be reported on the DMHC Financial Survey Report Form dated September 2018 and must be in compliance with California Code of Regulation 1300.75.4.

In accordance with the Provider Agreement, the medical group must maintain at all times ***adequate financial reserves*** to cover all risks assumed. The medical group must, at all times, comply with the financial performance standards as herein stated, including, but not limited to, unanticipated claims for referral services that are the potential responsibility of the medical group. The medical group shall meet or exceed Anthem's financial performance standards or covenants as follows:

1. Cash ratio of at least 90 percent (cash and/or equivalents plus marketable securities and HMO capitation receivables due within 30 days divided by total current liabilities) or Cash assets in the balance sheet equal to a minimum of 10 percent of total revenue, whichever is higher,
2. Total stockholders' Capital must equal to at least 8 percent of total quarterly revenue or 15 percent of total quarterly medical expenses, whichever is higher, however, if medical group's aggregate (all Health Plans) HMO Membership exceeds 10,000 lives, Anthem may at its discretion require medical group to maintain at the minimum a Paid-Up Capital at or above $50 per Member,
3. Maintain a working capital ratio of at least 1.5:1,
4. Maintain a debt-to-equity ratio (financial leverage) of not more than 200 percent,
5. Provision for incurred but not reported (IBNR) claims liability of at least two months of average monthly claims expenses.

In the event the medical group does not meet any of the regulatory solvency and Anthem financial performance standards, set forth herein or in the Provider Agreement, medical group shall, within 30 days upon request by Anthem, provide a ***Stand-by-Letter of Credit*** (SL/C) or ***Assigned Deposit*** as a contingency reserve, in an amount acceptable to Anthem. At the minimum, the SL/C must be equivalent to $50 for each HMO enrollee or at the discretion of Anthem, in order to mitigate risk.

Medical group shall maintain a system and monitor the financial viability of the group and all risk bearing subcontracting provider groups. Such system shall be consistent with section 1300.70 of title 28, CCR. Medical group/sub-contracting group is required to develop and implement corrective action plan (CAP) if it fails to meet the financial solvency and claims timeliness criteria (SB260, see below). The self-initiated CAP must be submitted to and approved by DMHC and Anthem in a timely manner.

Financial Audit Requirements – Access to Financial Data
The medical group agrees to provide Anthem access to, and a copy of the most recent quarterly and YTD or the annual audited balance sheet, income statement and cash flow, and DMHC submission copies upon completion of submission. If requested by Anthem, the medical group agrees to provide Anthem promptly with appropriate medical group accounting records upon request, and within a reasonable timeframe to allow the review, analysis or validation of the medical group financial information.

Accounting records will include, but are not limited to, the general ledger, subsidiary ledger, journal entries (together with the appropriate back-up documentation), accounts receivable (AR) aging schedules – including details of "Due From Accounts" and backups, risk and incentive receivables' aging schedule and backups, claims inventory aging schedule, IBNR claims lag schedule (or as appropriate), specific GL account details, and other financial data that Anthem may request from time to time and some reports should be in Excel format.

Other financial information includes, but is not limited to, the trial balance, bank statements, reconciliations, and certification of bank deposits. medical group also agrees to submit the Anthem's HMO Finance- Oversight financial review questionnaire, representation or financial statement certification, statement of renewal of required insurance policies, corrective action plans (if appropriate), together with pro-forma or projected financial statements (with detailed assumptions), and other reports as may be requested by Anthem. It does not preclude the submission of more frequent reports if Anthem deems it necessary.

Regulatory Solvency Grading Criteria
The above data requirements are needed to ensure Anthem receives sufficient information for purposes of monitoring the medical group's financial solvency and viability based on established Anthem financial covenants (performance standards) and/or solvency grading criteria mandated in ***Title 28, Section 1300.75.4*** of the CCR. The criteria include maintaining at all times:

1. A tangible net equity equal to or greater than DMHC required TNE per DMHC Financial Survey Grading Criteria
2. Positive working capital
3. Cash-to-Claim Ratio which is calculated as sum of cash, readily available marketable securities and HMO capitation receivables due within 30 days divided by sum of claims payable and IBNR equal to or greater than 75 percent, and
4. Estimate, accrue and document its methodology for IBNR claims liabilities on a monthly basis.

If the medical group relies on a sponsoring organization to maintain its financial solvency, the sponsoring must be approved by DMHC and Anthem in advance and the sponsoring may not be more than one year. Any extension to the one-year sponsoring limit must be requested at least three (3) months before one year sponsoring expire and be approved by DMHC and Anthem. Only a one-year extension may be granted at DMHC and/ or Anthem's discretion.

These solvency requirements are in addition to meeting the standard for timely claims resolution mandated by ***Title 28, Sections 1300.71 and 1300.71.38*** of the regulations (or "Claims Processing and Timeliness Regulations"). The medical group's failure to comply with the DMHC and Anthem performance standards and solvency regulations including the submission of all appropriate monthly quarterly and annual financial report requirements shall constitute a material breach of the Provider Agreement.

To ensure Anthem could act on solvency issues accordingly, the medical group must inform Anthem HMO Finance no later than five (5) business days from discovering that it has experienced any event that materially alters their financial condition or threatens its solvency.

Requests by an organization to extend the one (1) year period and to rely on a sponsoring organization during a subsequent period shall be submitted to the Department and may be approved at the Director's discretion.

Hospital Financial Review
Concurrent with the Policy to mitigate the risk with medical groups, a set of financial metrics has also been adopted by HMO Finance to evaluate the financial position of hospitals participating in the Anthem managed care program (capitation). The hospital is contractually required to receive monthly capitated payments from Anthem based on the Provider Agreement. The financial (performance standards) metrics are used as guideposts in the analysis of the hospital's financial capacity.

In addition to the financial metrics, applicable to medical groups (see prior discussions above); the following are used as a basis in the financial review of hospitals:

1. Minimum Working Capital ratio of 1.10:1,
2. Minimum Tangible Net Equity (total current assets less total liabilities less intangible assets) of $5 million,
3. Hospital Cash Ratio (cash and equivalents plus marketable investments, net patient receivables, HMO capitation receivables and board designated funds divided by total current liabilities) of at least 0.9,
4. Days Receivable of 70 Days or less,
5. Days Cash On Hand (DCOH) of at least 50 Days,
6. Positive Operating Margin for the immediate past three (3) years.

Additionally, we may also examine the hospital's key financial indicators and volume statistics. Anthem may also obtain data from the State of California on relevant hospital utilization statistics, detailed financial data on hospital management and operations. Like medical groups, capitated hospitals are contractually required to submit to Anthem their quarterly and annual financial statements (see above statement of policy on submission timeframe) to apprise Anthem on any hospitals experiencing financial difficulties or with emerging financial issues that could adversely affect their capacity to deliver contracted medical services.

In a financial review, non-hospital revenues and non-operating expenses are measured to ascertain the degree of relationship to the hospital's financial condition and/or its short-term survivability as a business enterprise.

Furthermore, Anthem would ascertain the hospital's compliance with laws or regulations that require substantial cash flow adjustments or test their capacity to access external funds (i.e., AB394 [staff ratio] and SB 1953 [seismic mandate]). It is also important to analyze the value of fixed assets deployed in generating revenues on a per licensed-bed basis.

Hospitals receiving SB1100 (SB855 funding and SB1255 emergency assistance [Disproportionate Share grant payments]) should be evaluated as to the degree of vulnerability without such financial aid. At the front end, Anthem may require the contracted hospital to submit to Anthem a SL/C amounting to

$300,000 or as may be determined by HMO Finance and Anthem Contract Management in order to mitigate the perceived financial risk.

Unlike medical groups, hospitals are not subject to the DMHC solvency grading criteria (SB260). Section 128740 of the California Health and Safety Code and Title 22 of the CCR, however, requires hospitals to file quarterly financial and utilization reports with the Office of Statewide Health Planning and Development (OSHPD) within 45 days after the end of the quarter.

Adjusted reports reflecting changes may be filed within four (4) months of the close of the hospital's fiscal year. Failure to file the required report would subject the hospital to pay a civil penalty of one hundred dollars ($100) a day for each day of delay.

Following the mandatory filing of the hospitals quarterly and annual financial statements per Sec 128740 of the CHSC and Title 22 of the CCR, Anthem also requires that hospitals must submit to Anthem a copy of the same quarterly and audited annual financial statements within the same timeframes.

Claims Timeliness Regulation And Reporting Requirements
Medical group is required to comply with claims settlement practices and dispute resolution mechanism (implemented under ***Section 1300.71 and 1300.71.38 of Title 28*** of the CCR). This is to ensure that all claims and disputes from any physician, hospital, medical facility and other healthcare entities are processed and resolved in an appropriate and timely manner.

Medical group shall, per regulations, submit a claims report, which includes the percentage of claims that have been timely reimbursed, contested, or denied during the quarter by medical group in accordance with the requirements of ***Sections 1371 and 1371.35*** of the *California Health & Safety Code*, *Section* ***1300.71 of Title 28*** of the CCR, and any other applicable state and federal laws and regulations, medical group agrees to provide Anthem with monthly and quarterly reports of claims processing timeliness, Provider disputes, and other applicable reports on the ICE Form Monthly/Quarterly Claims Timeliness Report (MTR) and Quarterly Provider Dispute Resolution Report (PDR) pursuant AB 1455 regulation required by Anthem and regulations.

The timeliness report must be sent to Anthem within 15 days after the end of each month and 30 days after the end of the quarter period. If less than 95 percent of all complete claims have been reimbursed, contested or denied on a timely basis, the claims report must also describe the reasons why medical group's claims adjudication process is not meeting the requirements of applicable law, any actions taken to correct the deficiency and the result of such actions. This claims report is used to monitor the financial status of the medical group and is not intended to change or alter existing state and federal laws and regulations relating to claims payment timeliness and settlement practices and timeliness. In addition, medical group shall, by regulations, effect payment to non-network Providers based on "reasonable and customary" value of their services subject to DMHC guidelines or pursuant to CCR, Title 28, Section 1300.71(a)(3)(B). Quarterly and annual reports on claims compliance are required based on timeframes set by regulation or by the DMHC.

For more information refer to the **Monthly Report of Claims Processing Timeliness and Overall Percent of Denial Accuracy for Anthem Commercial Members.** This report is located on the **Health Industry Collaboration Effort (HICE)** website at **http://www.ICEForHealth.org/**. Steps to find the report are below:

- *Click on this link:* **Monthly Report of Claims Processing Timeliness**, then choose:
  - Approved HICE Documents

- Claims
- Approved Claims Documents
- ICE_Claims_Comm_MoQtr_Final_041409Instruction rev 03_10 (2)

At the request of Anthem, the medical group will provide a claims aging schedule, including both dollars and number of claims outstanding as of a certain period. If necessary, a historical record of a particular medical Provider's claims (billings), as well as the record of payments/denials made by the medical group in any form, may also be required during a claims or financial audit, or as often as necessary. The medical group will provide separate claims aging reports for contracted and non-contracted physicians, hospitals and/or other healthcare professionals in a format as determined by Anthem.

Moreover, Anthem is mandated by the Centers for Medicare & Medicaid Services (CMS) to require delegated medical groups with Medicare Advantage products to submit a CMS Status Report on a quarterly basis. This is in addition to the Claims Timeliness Report as indicated above. The mailing address for the Anthem financial and claims reporting is located in *Section 2, Quick References,* under *Finance*. *Click on this link:* **Contact Information**

For Financial Statements and related information, *Email:* **BlueCrossFSsubmit@Anthem.com**

For Claim Reports and related information, *Email:* **Rboclaimsreports@Anthem.com**

Out-Of-Area Emergency Services
The admitting hospital should notify the HMO Clinical Ops Utilization Management Department within 72 hours after a Member is admitted to a hospital for out-of-area emergency care. In the event the medical group is contacted by the hospital, call the HMO Clinical Ops Utilization Management Department at the phone number provided in *Section 2, Quick References,* under *Case Management*.
Click on this link: **Contact Information**.

When the Member is stable, Anthem contacts the medical group to facilitate the Members transfer to a facility in the medical group's service area.

Anthem HMO and POS Division of Financial Responsibilities (DOFR)
Medical groups should refer to their specific DOFR, Exhibit A of their Provider Agreement.

HMO Pharmacy & Medical Claims Paid Reports
The HMO Pharmacy Claims Summary is a financial summary report that provides pharmacy information, such as the cost of a drug, formulary compliance percent and generic percent.

The quarterly HMO Medical Paid Claims Report is designed to be used in conjunction with the monthly Pharmacy Clinical Report. These reports can be accessed via the Availity Home Page, as follows:
Select **Payer Spaces>Anthem Blue Cross>Applications Tab>Provider Online Reporting (POR).** Select **Organization**, then hit **Submit.** This will open the **Home Page on POR**. Select **Programs tab**>select **A Program**>choose **Reports,** then you will be able to choose **HMO Claims Reports** or **Pharmacy Claims Reports.**

7 | Centers of Medical Excellence (CME)

Anthem currently offers access to Centers of Medical Excellence (“CME”) programs in solid organ and blood/marrow transplants, bariatric surgery, cancer care, cardiac care, maternity, spine surgery, knee/hip replacement surgery fertility care, cellular immunotherapy – CAR-T, gene replacement 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 and Blue Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage.

The BCBSA refers to its designated CME Providers as Blue Distinction Centers for Specialty Care™. Using objective information and input from the medical community, the BCBSA has designated 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 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: **Centers of Medical Excellence**.

Transplant

Nearly 105,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of December 2022. There were nearly 41,000 organ transplants in 2021. In 2022, the U.S. reached 1 million transplants.

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

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

The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant programs. When BDCT and Anthem CME are combined, Members have access to over 800 transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver/kidney, pancreas and combined kidney/pancreas transplant.

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

According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 30.3 million, and the percent of adults with diagnosed heart disease is 12.1%. Heart Disease is the #1 Cause of death in the United States.

Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 21 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.

Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery and cardiac valve surgery).

Bariatric Surgery
Blue Distinction Centers for Bariatric Surgery® launched in 2008. According to the National Center for Health Statistics report released in October 2017 Prevalence of Obesity among Adults and Youth has grown to more than one-third (42.4%) of U.S. adults which have been diagnosed with obesity, and 40% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.

Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (“ASMBS”) and the American College of Surgeons (“ACS”), and is subject to periodic re-evaluation as criteria continue to evolve.

The 2020 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”) accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (“ASC”).

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

Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery
Blue Distinction Centers for Spine Surgery® launched in November 2009. Studies confirm that as many as eight out of ten 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 onsite 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 onsite ICU. Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement and revision surgeries.

Maternity Care
Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise, a commitment to quality care, and safety during the delivery episode of care, which includes both vaginal and cesarean section delivery.

The Maternity Care designation uses publicly available data from Hospital Compare data, which includes the Early Elective Delivery (PC-01), Cesarean Section (PC-02) and selected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”). As well as additional measures to support safe practices in childbirth.

Substance Use Treatment and Recovery
Blue Distinction Centers for Substance Use Treatment and Recovery launched in January of 2020 to address the treatment of substance use disorders, including opioid use disorder.

The program aims to improve patient outcomes and cost by addressing the fragmented delivery of substance use disorder treatment. Designations are awarded based on quality criteria that support delivery of timely, coordinated, multidisciplinary, evidence-based care, with a focus on quality improvement and patient-centered care.

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

Ventricular Assist Devices
Anthem's Centers of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end stage heart failure.

According to the Centers for Disease Control and Prevention, Heart failure reports that about 5.7 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly healthcare services.

Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

Cellular Immunotherapy (Chimeric Antigen Receptor Therapy - "CAR-T")
The U.S. Food & Drug Administration (FDA) has approved new cellular immunotherapy products called Chimeric Antigen Receptor T-cell (CAR-T); a CD19-directed genetically modified autologous T cell immunotherapies that provide new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells. There are six (6) Chimeric Antigen Receptor T-cell therapies (CAR-T) products listed below, approved by the FDA. This list continues to grow as new products are approved:

1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
2. Kymriah® (tisangenlecleucel) for treatment in Pediatric and Adult Patients
3. Tecartus™ (brexucabtagene autoleucel) for treatment in Adult Patients
4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
6. Carvykti™ (ciltacabtagene autoleucel) for treatment in Adult Patients

These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting, and Care and follow-up continues over the first year.

These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.

Anthem has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by our Bone Marrow National Transplant Quality Review Committee. Currently we have ten 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.

8 | Medical Management Programs & Policies

Medical Management Overview

Delegated medical groups should follow the information listed below. For Rural HMO Members, HMO administration sites and de-delegated medical groups, see Chapter: Delegation Process Exceptions.

The purpose of the Medical Management Program is to determine if the medical services proposed or rendered are:

- Medically necessary
- Covered under the Members Anthem Blue Cross (Anthem) EOC, and/or
- Performed at both the appropriate place and level of care

With limited exceptions, Providers will not be reimbursed for services that are not a covered benefit, not medically necessary, or for which correct procedures have not been followed (e.g., notification requirements, preauthorization, or verification guarantee process). NCQA Accreditation standards require that all healthcare organizations, health plans and medical groups, delegated for utilization/medical management, distribute a statement to all Members Providers and employees who make UM decisions affirming the following:

- UM decision-making is based only on appropriateness of care and service and existence of coverage.
- Care Providers or other individuals are not specifically rewarded for issuing denials of coverage or service.
- Financial incentives for UM decision-makers do not encourage decisions that result in under-utilization.

Regardless of the Medical Management Program determination, the decision to render medical services lies with the Member and the attending care Provider. If the Provider and Member decide to move forward with the medical services that have been denied as part of the pre-authorization process by Anthem or the medical group, all services related to that denial will not be covered. Anthem Medical Directors are available to discuss their decision and criteria with you.

Delegated Utilization Management

The Utilization Management (UM) process for HMO Members is primarily delegated to the medical group. UM that is not delegated to the medical group is retained by Anthem or an Anthem affiliate.

Most aspects of in-area healthcare for Anthem HMO Members are reviewed and provided by HMO medical groups. This includes in-area emergency care, as well as care that must be provided by non-network Providers due to the group's inability to provide care in-network.

The following care is not delegated to medical groups (see the appropriate referenced sections) for UM:

- Behavioral Health
- Experimental/ Investigational Procedures
- Clinical Trials
- Out-of-Area/Out-of-State/Out-of-Country Emergency Inpatient Admissions
- Second Opinions

- Transgender Services
- Transplant, CAR-T, and Gene Replacement Therapy

Anthem delegates Medical Management to the medical groups that demonstrate compliance with Anthem established standards for the medical management function. Care Providers associated with these delegated medical groups may use the medical group's medical management office and protocols for all authorizations for which the medical group is delegated. The medical group's medical management protocols must be in alignment with those of Anthem's Medical Policy and Clinical Guidelines. The delegated medical group's medical management protocols and procedures must comply with all applicable accreditation, State and Federal regulatory requirements. Policies must include established UM denial system controls, policies and processes to protect and monitor data from unauthorized modification.

If you have questions concerning Medical Management delegation, contact CA Contract Support via the web address provided in *Section 2, Quick References*, under *CA Contract Support*.
Click on this link: **Contact Information**

Delegated Medical Management

Compliance & Oversight
Anthem will perform or require the following as part of delegate medical group oversight:

- Pre-contractual audit before delegating medical management functions, including providing a description of the medical groups UM system controls to protect and monitor data from unauthorized modifications.
- An initial audit (Post-Go-Live audit) within 90 – 120 calendar days after the contract effective date to measure compliance with Anthem's standards.
- An annual audit of the delegated medical group to help ensure continued compliance with accreditation, State and Federal regulations.
- A focused or off-cycle audit based specific activity.
- Sanctions or revocation of delegated UM duties for continued non-compliance with Anthem standards.
- Delegate development and implementation of a corrective action plan when the medical group is non-compliant with Anthem standards.
- Delegate generated required reports as outlined in the delegation agreement that meet applicable regulatory requirements and accreditation standards.

Notification Requirements for Facility Admissions (Shared Risk Groups)
Contracted facilities are accountable to provide timely notification to both the delegated medical group and Anthem at the phone or fax numbers provided in *Section 2, Quick References*, under *HMO Clinical Ops Utilization Management Department*. *Click on this link:* **Contact Information**

All inpatient status cases, including changes in level of care. Within 24 hours of admission or the next business day following a weekend or holiday.

Maternity Admissions. Normal vaginal delivery or c-section delivery must be notified on or before the end of the mandated period 48 hours or 96 hours respectively.

NICU and High-Risk OB Admissions. The delegated medical group must have a clearly defined process with the contracted facility whereby the facility provides the medical group and Anthem information on all facility admissions, updates on Member status and discharge dates on a daily basis as indicated by the Members condition.

Emergency admissions. Notification to the medical group shall occur once the Member has been stabilized in the emergency department and prior to inpatient admission. Proper notification is required by Anthem on the day of admission for timely and accurate payment of facility claims.

Authorization Log and Denial Log Submission (Shared Risk Groups)
Authorization logs for all inpatient acute, observation status and SNF cases as well as denial logs must be accurately submitted at least twice a week or as directed in the Delegation Agreement. In the event there are no inpatient acute, observation statuses or skilled nursing facility cases to report, the medical group is required to submit its weekly authorization log indicating either “no activity” or “no admissions” for each of the designated admission service type specified in this section and for the applicable reporting time period.

Authorization logs covering facility and skilled nursing facility daily information includes the following data elements:

- Member ID
- Member Name
- Member Date of Birth
- Attending Care Provider: (Name and Address, with TIN if available)
- Facility Care Provider: (Name and Address, with TIN if available)
- Admitting Diagnosis (ICD-10-CM or its successor code)
- Actual Admission Date
- Actual Discharge Date
- Level of Care (i.e., bed type, observation status, outpatient procedures at acute facilities)
- Length of Stay (LOS) (i.e., number of days approved, as well as the number of days denied)
- Procedure/Surgery (CPT Code)
- Discharge Disposition
- Planned Admission Date
- Planned Discharge Date
- Service Type
- Authorization Number (if available)

The medical group must have a clearly defined mechanism for determining medical necessity and authorizing outpatient services. The medical group must be capable of submitting, pursuant to plan demand, authorization or denials for all services for which the medical group has authorized or denied care on behalf of Anthem.

Authorization, Denials & Timeframes
Based on the hierarchy of review guidelines, Anthem and the delegated medical groups provide the following service reviews:

- Pre-Service Review

- Continued Stay Reviews/Care Coordination Management
- Post-Service Clinical Claims Review

Authorization Criteria
Anthem and medical groups delegated for utilization/medical management, review nationally recognized criteria to determine medical necessity and appropriate level of care for services whenever possible. Anthem and delegated medical groups will utilize multiple resources and guidelines to determine medical necessity and appropriate level of care. Individual criteria will be provided upon request.

Authorizations Based Upon the Following Hierarchy of Review:

1. Federal and State mandates and other requirements
2. Member benefits
3. Anthem Medical Policies
4. Clinical Utilization Management (UM) Guidelines

Clinical Utilization Management (UM) guidelines adopted for use by Anthem to review potential coverage for the requested service can be an Anthem Clinical UM Guideline (CUMG) or guidelines from AIM, IngenioRx, or Milliman Care Guidelines (MCG).

The decision-making criteria used by Anthem is evidence-based and consensus-driven. We periodically update criteria as standards of practice and technology change. We involve practicing physicians in these updates and notify Providers of changes through our Provider Newsletter and E-Update communications.

Denial of Services
A denial/adverse determination may be issued by Anthem or a delegated medical group when medical necessity criteria for a healthcare service is not met, services for a non-covered benefit is requested.

If you disagree with a Medical Management decision to deny requested healthcare services, you may request an appeal on behalf of the Member or submit a Provider Dispute. Only a Medical or Behavioral Health Provider who possesses an active professional license or certification can deny services for lack of medical necessity, including the denial of:

- Procedures
- Outpatient Services, e.g., Home Health, Infusion
- Hospitalization
- Equipment

The written denial notice serves many purposes and is an important component in the Members chart and the medical group's records. The denial letter serves to document Member and care Provider notification and must include:

- The specific service(s) denied, modified or partially approved
- The reason the service is being denied, modified, or partially approved including:
    - Clear and concise explanation of the reasons for the decision, insufficient detail, using an easily understandable summary of the criteria, so that all parties can understand the rationale behind the decision
    - Description of the criteria or guidelines used, reference to the benefit provision, protocol or

other similar criterion on which the denial decision is based, and

- How those criteria were applied to the Members condition (Member-specific information)
- Specific name of the referenced criteria
- Notification that the Member can obtain a free of charge copy of the actual benefit provision, guideline, protocol or other similar criterion on which the denial decision was based, upon request (Commercial)
- Notification that the Members care Provider can request a peer-to-peer review with the physician reviewer who made the decision to deny
- The specific reference to the EOC provisions to support the decision applies to benefit denials only
- Contractual rationale for benefit denials
- Alternative treatment and/or Provider options offered, if applicable (not applicable for retrospective review or non-covered benefit denials)
- Grievance and Appeal processes, including:
  - Information about when, how and where to submit an appeal
  - Information regarding the Members right to appoint a representative to file an appeal on the Members behalf
  - Members right to submit written comments, documents or other additional relevant information
  - Information notifying the Member and their treating care Provider of the right to an expedited appeal for the time-sensitive situations (not applicable for retrospective review)
  - Information regarding the Members right to file a grievance or appeal with the applicable state agency, including information regarding the independent medical review process (IMR), as applicable
  - Information that the Member may bring civil action, under Section 502(a) of Employee Retirement Income Security Act (ERISA), if applicable; and Information regarding the Federal Employee Health Benefits Plan appeals process, if applicable
  - The notice to the requesting care Provider must include the name and direct phone number of the Healthcare Professional responsible for the decision
  - List the specialty of the Provider who reviewed the appeal. The specialty of the Provider must be in alignment to the services requested

Emergency Medical Conditions and Services
In the event of an emergency, Members can access emergency services 24 hours a day, 7 days a week.

In the event the emergency room visit results in the Members admission to the hospital, Providers must contact the delegated medical group within 24 hours or one business day if the Member was admitted on a weekend or holiday.

Members who call their PCP's office reporting a medical emergency (whether during or after office hours) are directed to dial ☎ **911** or go directly to the nearest hospital emergency department. All non-emergent conditions should be triaged by the PCP or treating physician, with appropriate care instructions given to

the Member.

Emergency Stabilization and Post-Stabilization
The emergency department's treating physician determines the services needed to stabilize the Members emergency medical condition. After the Member is stabilized, the emergency department's physician must contact the Members medical group for authorization of further services, including post-stabilization admission. The Members medical group is listed on the back of the ID card. If the medical group does not respond within 30 minutes, the needed services will be considered authorized, and the attempt must be documented in the Members medical record in order to be authorized.

All continued inpatient stays are reviewed to determine whether the stay is medically necessary, including the length of stay. The transfer process for out-of-network/out-of-area admissions requiring transfer to an Anthem-contracted facility, to the medical group in-area facility or to a higher level of care includes the following:

- The attending/treating physician determines whether the Member is stable for transfer.
- The attending/treating physician discusses the potential transfer with the medical group.
- To facilitate the transfer, the medical group is required to contact the attending/treating physician within 30 minutes of the call.
- The attending/treating physician must document and sign orders stating that the Member is stable for transfer.
- Transfers of children require the signed permission of the parents, except in cases to transfer to a higher level of care.
- The emergency department should send a copy of the emergency room record to the PCP's office within 24 hours. The PCP should:
    - Review the chart and file it in the Members permanent medical record
    - Contact the Member
    - Schedule a follow-up office visit or a specialist referral, if appropriate

All Providers who are involved in the treatment of a Member share responsibility in communicating clinical findings, treatment plans, prognosis and the psychosocial condition of such Member with the Members PCP to ensure effective coordination of care.

Out-Of-Area Inpatient Emergency Admission
Out-of-area emergency services include hospital and professional services rendered to an Anthem Member at the distance outlined in the Out of Area Services Definition in your Provider Agreement. Providers should notify the Anthem HMO Clinical Co-Management department as soon as possible, and in no event greater than three business days after a Member is admitted to a hospital for out-of-area emergency care.

The Anthem HMO Clinical Co-Management nurse will contact the Provider and medical group to facilitate the Members transfer to a facility in the medical group's service area, when the Member becomes stable for transfer.

To report an out-of-area emergency admission, call the Anthem HMO Co-Management Intake Team at the phone or fax number provided in *Section 2, Quick References*, under *Anthem HMO Co-Management Department*. *Click on this link:* **Contact Information**

Referrals
Each Member is assigned a PCP at the time of enrollment. The PCP has primary responsibility for coordinating the Members overall healthcare, including behavioral healthcare, and the appropriate use of pharmaceutical medications.

Referrals to Specialists
The delegated Provider group is responsible for the referral authorization process when a request is made to refer a Member for services. (Refer to the delegated group's pre-authorization list, as applicable). The following medical services are examples where a referral authorization may be necessary:

- Outpatient services
- Laboratory and diagnostic testing (non-routine, performed outside the delegated medical group's facility)
- Specialty consultation/treatment

The medical group, PCP and/or other referring care Provider is responsible for verifying eligibility and participating care Provider listings on all referral authorization requests, so that the referral is to the appropriate in-network care Provider. The Provider group must comply with the following procedures:

- When a Member requests specific services, treatment or referral to a care Provider, the PCP or treating care Provider shall review the request for medical necessity.
- If there is no medical indication for the requested treatment, the care Provider shall discuss an alternative treatment plan with the Member.
- If the treatment option selected by the Member requires a referral or prior authorization, the PCP or treating care Provider must submit the Members request to the medical group's Utilization Management Department or its designee for determination.
- The PCP or treating care Provider should include appropriate medical information and commentary on the referral regarding why they believe the requested treatment is or is not indicated and alternative treatments as appropriate.
- If the request is not approved in whole or in part, the medical group must issue a denial letter to the Member, specific to the requested services, treatment or referral that complies with the applicable State and Federal requirements.

Referral Authorization Form
Effective July 1, 2021, we are asking all medical groups to submit details of their specialty referrals on a monthly basis to Anthem. This data will help us demonstrate to the DMHC that Anthem and its medical groups are providing accessible and available medically necessary services to our HMO Members. Below are the instructions on how to set up electronic data submissions to Anthem, and the data elements required.

Most of you are familiar with Availity and use it on a regular basis for electronic submission; additional information will be forthcoming regarding the data elements required for this out-of-network specialty referral reporting.

- If you use practice management software, have your Availity Essentials Administrator use the following path to enroll: **My Providers** > **Enrollment Center** >**Transaction Enrollment**.

- If you use a clearinghouse or vendor, work with them to ensure they have the capability to exchange these transactions.

Useful Documents

- The Availity EDI Companion Guide communicates Availity-specific requirements and other information that supplements requirements and information already provided in standard EDI and HIPAA communications. *Link:* **Availity Batch EDI Standard Companion Guide**
- Anthem specific companion guide communicates requirements for submitting these transactions. These are located on the Company website at **EDI**
- The Availity Quick Start Guide will assist you with any EDI connection questions you might have: *Link:* **EDI Connection Services Startup Guide**

HMO Clinical Co-Management Program

Anthem HMO provides an HMO clinical Ops team for medical groups. This program is designed to provide an increased level of assistance and resources to our medical group's UM and discharge planning teams through identification of readiness for discharge or transfer to a lower level of care and available Member resources to assist with alternative care settings.

The expectations of medical groups are to continue review processes per delegation agreement and provide HMO Clinical Ops nurse with clinical review in accordance with regulatory and accreditation timeframes.

The medical group will:

- Provide HMO clinical Ops nurse with requested clinical information and clinical review in accordance with regulatory and accreditation timeframes.
- Anthem's Clinical Ops team will perform the clinical review for emergent out of area admissions and will collaborate with the medical group in repatriation of Members, as medically appropriate to the contracted facility of record for the medical group.
- Communicate discharge planning needs to HMO Clinical Ops team; HMO Clinical Ops team may assist upon request.
- Provide Medical Management Programs. Anthem will provide Case Manager and Disease Management support, if medical group CM/DM program is not available.
- Provide current medical group UM team contact information.
- Conduct reviews for medical necessity and benefit determinations, using the hierarchy of decision- making tools:
    - Federal and State mandates
    - Member benefits
    - Anthem Blue Cross Medical Policies
    - Clinical Utilization Management (UM) Guidelines
    - Note: medical groups are delegated for utilization review and after considering Anthem Clinical Guidelines and Medical Policies, may adopt third-party guidelines such as Carelon Rx or MCG.
    - Local reimbursement and claim processing guidelines as appropriate

The Anthem HMO Clinical Operations Team is committed to providing support to our delegated CA HMO Provider Group Utilization Management (UM) programs. This support strengthens collaboration between Anthem and Provider Groups and promotes adherence to the delegated responsibilities of appropriately managing and redirecting UM referrals to the health plan's contracted providers for the member's network. While UM referrals to Anthem par providers in the member's network should always be occurring, Anthem has seen an increase in out of network referrals from our HMO Individual (Exchange) Pathway network Provider Groups.

Commencing in the fourth quarter of 2024, Anthem's HMO Clinical Operations Team will track and monitor PMG/IPA UM activities focusing on out-of-network (OON) utilization management for our **HMO Individual Pathway** members.

Anthem requires PMG/IPAs handle OON UM for our **HMO Individual Pathway** members as follows:

1. **Utilization of appropriate networks**: Our CA HMO Individual Pathway plan consists of a tailored network of providers. Anthem expects delegated HMO Provider Groups to coordinate non-urgent/emergent services to the HMO Individual Pathway contracted providers, potentially helping to lower our member's healthcare cost.
2. **Prompt notification of all out of network (OON) referral and authorization requests to Anthem**: If a member is being referred to an out-of-network provider, we request immediate notification to Anthem. Delays in such notifications can limit the level of assistance we can provide regarding alternative options.
3. **Collaboration with the Anthem HMO Clinical Ops Team**: Anthem's HMO Clinical Ops Team provides assistance to our delegated HMO Provider Group's UM and discharge planning teams. This encompasses identification of readiness for discharge, transfer to a lower level of care, and utilization of appropriate in-network providers based on the member's plan contract. Collaborating with our team will ensure timely coordination of member transfers **(repatriation)** or guiding members to the appropriate in-network treatment facility **(redirection)**.

Standing Referral/Extended Referral for Care by a Specialist
The delegated medical group is required to develop procedures by which a Member may receive a standing referral/extended referral for specialty care. The procedures shall provide for a standing referral or extended referral to a specialist or specialty care center if the Member and PCP, in consultation with the specialist, determine that the Member requires:

- Continuing care from a specialist or specialty care center over a prolonged period of time; and/or
- Extended access to a specialist for a life-threatening, degenerative or disabling condition that requires coordination of care for the Member by such specialist.

The treatment plan may limit the number of visits to the specialist, limit the period of time that the visits are authorized, and/or require that the specialist provide the PCP with regular reports on the care provided to the Member.

For an extended specialty referral, the requesting PCP and the specialist should determine which healthcare services each of them will manage. The PCP shall record the reason, diagnosis, or treatment plan necessitating the standing referral. The specialist must refer the Member back to the PCP for primary care.

Extended Referrals to Specialists
The delegated medical group must have a written process for extended referrals to specialists when the PCP and the medical group's Medical Director agree that extended treatment of the Members condition is necessary.

To comply with State laws and regulations, the delegated medical group must identify Providers within their group who qualify to treat conditions such as Cancer, Chronic Renal Disease, Diabetes, HIV/AIDS and Rheumatoid Diseases. If there are no such Providers within the medical group, then an operational process must be in place, to refer Members to a qualified specialist outside of the group.

Second Opinion Review
The delegated medical group is responsible for arranging second opinions and specialty care with Providers within or affiliated with the Members medical group. Working with the medical group supports and improves the coordination and quality of the Members medical care.

When the Member has seen their PCP, and wants a second opinion, the Member has the right to a second opinion by another appropriately qualified healthcare professional within their medical group. If there is no appropriately qualified healthcare professional within their medical group or the Member is requesting a second opinion from a specialist that is not participating with the medical group, then Anthem will authorize a second opinion by another California PCP or specialist within the Anthem network, taking into account the Members ability to travel.

For urgent requests, a decision will be made within a timeframe appropriate to the Members medical condition, not to exceed 72 hours after the plan's receipt of the request. For non-urgent requests, a decision will be made within five (5) business days of receipt of the information reasonably necessary to make a decision.

Reasons for requesting a Second Opinion include, but are not limited to:

- Questions about the reasonableness or necessity of recommended surgical procedures.
- Questions about the diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including but not limited to, a serious chronic condition
- The clinical indications are unclear or complex and confusing.
- A diagnosis is in doubt because of conflicting test results.
- The treating healthcare professional is unable to diagnose the condition.
- The treatment plan in progress is not improving the medical condition within an appropriate period of time given the diagnosis and plan of care.
- The Member has attempted to follow the plan of care or has consulted with the initial Provider about serious concerns regarding the diagnosis or treatment plan.

Authorization for a Second Opinion is a one-time consultation only. The visit does not include testing, x-rays, lab work, follow-up visits, procedures or surgery. The Member will need to bring their x-rays, lab work and medical records with them to the appointment. Any treatment recommended by the Second Opinion Provider will need to be obtained through the delegated medical group.

If you have questions regarding the Second Opinion Program, call the phone number provided in *Section 2, Quick References*, under *Transition Assistance & Second Opinion*.
Click on this link: **Contact Information**

Click on this link for a Second Opinion Request Form: **Second Opinion Request Form**

Experimental/Investigational Services Including Clinical Trials
Anthem does **not** delegate utilization management activities related to requests for authorization of experimental/ investigational therapies or for clinical trials. If the medical group receives a request for authorization of experimental/investigational services or clinical trials, the group must submit the request to the HMO Co-Management Department (UM) via fax at the number provided in *Section 2, Quick References,* under *Anthem HMO Co-Management Department*. *Click on this link:* **Contact Information**

The request must be submitted utilizing the Request for Health Plan Initial Determination for Clinical Trial/Investigational Form for HMO Members, as well as all relevant clinical documentation. We will issue a written determination notice to the Member and the requesting care Provider.

Drug requests for experimental/ investigational services must be faxed with other documents.
Link: **Prescription Drug Prior Authorization Form**

The table below outlines the review process and timeframes for conducting the initial determination on experimental/investigational treatment.

Procedure/Activity	Responsible
Medical group receives an authorization request from a Member or Members practitioner for investigational/ experimental treatment or a clinical trial (medical group should fill out the form completely and include the names, phone numbers and fax numbers for the appropriate contacts, including the requesting Provider.) Anthem UM receives the completed **Request for Health Plan Determination Form** from the medical group.	Medical group must complete the **Request for Health Plan Initial Determination Form** This form and all pertinent medical records, related documentation and applicable Anthem Medical Policy(s) used by the medical group to identify investigational status must be submitted on the same day the request is received to Anthem's HMO Co-Management Department (UM) at the phone or fax number provided in *Section 2, Quick References,* under *Anthem HMO Co-Management Department.* *Click on this link:* **Contact Information** **Note: Requests for EXPEDITED REVIEWS must be faxed the same day the request is received**. UM will review the request and make a review determination if: • treatment is denied as investigational/ experimental, Anthem will issue a denial letter to the Member and Provider with a copy to the medical group. • treatment is determined **not** to be investigational; the medical group is notified and is responsible for the medical necessity determination and Member/ Provider notification of the review outcome.

Procedure/Activity	Responsible
	For Clinical Trials (CT): Anthem will administratively pay all routine patient costs associated with the approved clinical trial and will notify all applicable parties per regulatory protocol.

Anthem's Transplant Team

The Transplant Team's review of services includes Solid Organ (kidney, heart, lung, liver, pancreas, intestinal, multi-visceral, combination organ transplants) and Bone Marrow and Stem Cell (autologous and allogeneic) transplants, CAR-T, and gene replacement.

All delegated medical groups must notify the CME Transplant and Special Therapy department when a Member is referred for evaluation, requires an authorization for transplant and admitted for transplant within one business day. Send Referrals to Anthem at the address or phone number provided in *Section 2, Quick References*, under *CME Transplant and Special Therapy department*.
Click on this link: **Contact Information**

Transplant medical necessity review Is the responsibility of the Anthem Transplant Team. This includes initial evaluation, prior authorization, inpatient concurrent review, and discharge planning. The initial evaluation involves the Anthem Transplant Team reviewing member benefits and verification that the requested facility meets network requirements, before consultation with the facility Transplant Team.

Transplant, CAR-T, and Gene Replacement therapy global period is outlined on the contract attachment provided upon approval of the service. During this global period the Transplant Team will review the transplant services for the member. Post global period, the UM review is the responsibility of the medical group.

Financial responsibility for transplant and non-transplant related medically necessary covered services remain as described in the Division of Financial Responsibilities matrix in the Provider Agreement.

Post-Transplant, the Anthem Transplant Case Manager works in conjunction with the Members transplant team, PCP, and other clinicians to complete an assessment of the Members healthcare needs, develop, implement and monitor a care plan, coordinate services and re-evaluate the care plan for the Member. All care Providers must obtain prior authorization for transplant evaluations and transplant surgery, regardless of financial risk. Transplant evaluations and surgery must be performed at one of Anthem's Centers of Excellence, or facilities approved by Anthem Transplant Medical Directors.

Refer To The Anthem Centers Of Medical Excellence (CME) Transplant Network Contracts Operations Manual *(referenced in Section 6 of this Provider Manual)*
Authorization and management of all non-transplant-related (e.g., medically necessary, covered services for the Member) remain the responsibility of the delegated medical group. Non-transplant related services include those services needed to treat the Members underlying disease and maintain the Member until transplant can be completed (e.g., ventricular assist devices/ mechanical circulatory support devices).

Medical Policy Formation
The Anthem Medical Policy Committee (MPC) is the authorizing body for Anthem Medical Policy and Clinical Utilization Management (UM) Guidelines, which serve as a basis for coverage decisions. The MPC uses the resources of the Office of Medical Policy & Technology Assessment (OMPTA) and the

Medical Policy & Technology Assessment Committee (MPTAC) for the development of Anthem medical policy and Clinical UM Guidelines, which the MPC then reviews for use in California.

OMPTA develops medical policy and clinical UM guidelines (collectively, "Medical Policy") for Anthem. The principal component of the process is the review for development of medical necessity and/or investigational 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 contract provisions/exclusions, take precedence over Medical Policy and must be considered first in determining eligibility for coverage.

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, are provided in *ADMIN.00001 Medical Policy Formation*.
Link: **Medical Policy Formation**

Medical Policy and Clinical Utilization Management ("UM") Guidelines Distinction
Medical policies 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 policies may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines address medical necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay, place of service and level of care. In addition, medical policies are implemented by all Anthem Plans, while clinical UM guidelines are adopted and implemented at the local Anthem Plan or line of business discretion.

Medical Policies and Clinical Utilization Management (UM) Guidelines are Posted Online at Anthem.com
All Anthem medical policies and clinical UM guidelines are available to the public on our website, which provides transparency for Providers and Facilities, Members and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the Anthem website but are available upon request.

To locate Medical Policy online, go to **Anthem.com.** Select **For Providers**, and then under the **Provider Resources** heading select the **Policies, Guidelines & Manuals** link. Select your **State**. Choose **View Medical Policies and UM Guidelines**, **Accept the Disclaimer (click on continue)**, then enter a **keyword or code** or choose **Full List Page**, or click on this link: **Medical Policy and Clinical UM Guidelines (for Local Plan Members)**

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

To view the list of specific UM Guidelines adopted by California, click on this link:

Clinical Utilization Management (UM) HMO Guidelines for California

Other Criteria
In addition to Medical Policy and Clinical Utilization Management (UM) Guidelines Anthem maintains for coverage decisions, Anthem may adopt criteria developed and maintained by other organizations. Where Anthem has developed a policy that addresses a service also described in one of these other sets of criteria, Anthem's policy supersedes. To access these other criteria, go to **Anthem.com**. Select **For Providers,** under **Provider Resources** select **Policies, Guidelines & Manuals**, then select, Select **Medical Policies & Clinical UM Guidelines** and scroll down to **Other Criteria** and Select the specific criteria needed.

9 | Quality Improvement

Quality Improvement Program Overview

Blue Cross of California d/b/a Anthem Blue Cross is a healthcare services plan licensed under California Health and Safety Code §§1340 *et seq*. Anthem Blue Cross Life and Health Insurance Company, Inc. is an insurer licensed under the California Insurance Code. Throughout this document, Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company, Inc. shall collectively be referred to as "Anthem" or "health plans". Anthem offers medical and specialty health plans throughout the state of California including individual and group products. Individual Qualified Health Plans are offered by Anthem Blue Cross.

The Quality Improvement ("QI") Program Description (hereinafter referred to as the "QIPD") defines the quality infrastructure that supports the QI strategies. The QIPD establishes QI program governance, scope, goals, objectives, structure and responsibilities encompassing the quality of medical and behavioral healthcare and services accessible to Members.

- The annual QI Work Plan is a dynamic process and reflects ongoing progress made on quality activities. The QI Work Plan includes measurable objectives for the year to determine how well the health plan is performing, including activities addressing quality of clinical care, safety of clinical care, quality of service and Members' experience.
- The QI Program Evaluation assesses outcomes of medical and behavioral health programs, and activities toward established goals and objectives.

In the QI Program Evaluation, priority metrics are evaluated to assess performance and determines the effectiveness of the QI program. It summarizes completed and ongoing activities, in addition to providing a high-level overview of outcomes and effectiveness. The QI Program Evaluation provides the opportunity to identify areas for improvement and determine if changes are required to the program structure based on the findings such as, but not limited to evaluation of how QI program goals and objectives were met.

Healthcare is local and Anthem has a strong local presence required to understand and support Member needs and provide access to covered care. Anthem is well positioned to deliver what Members want: innovative, choice-based products, distinctive service, simplified transactions and better access to information for quality care. Local presence and broad expertise create opportunities for collaborative programs that support Providers and Facilities achieving clinical quality and excellence. Participating Providers and Facilities are expected to cooperate with quality activities. Commitment to health improvement and care management provides added value to Members and Providers – helping improve both health and healthcare costs. Anthem takes a leadership role to improve the health of communities and is helping to address key healthcare issues.

Guided by its whole health, Anthem uses digital-first solutions to support provisions of exceptional experiences, affordability, quality and broadened access to consumers and communities. Our digital solutions are the driving force behind shaping our strategy. Digital access to cares is one of the enablers that allows us to create value, respond to societal shifts and meet market and consumer needs. We have a continued focus on integrating data, analytics, insights and digital technologies into every aspect of the business.

Goals and Objectives

The goals and objectives support Anthem's vision and values. They are responsive to the changing needs of Members, Providers, Facilities and the healthcare community; and focus on being a valued health partner across the healthcare continuum. Anthem implements evidence-based interventions from both external and internal sources to help build and deliver the best value to customers.

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

Community Health Initiatives

Anthem is partnering with national organizations to implement innovative community-based programs that address health equity across a broad range of dimensions. These programs are made available to the public at no-cost and can be found at this link: **Anthem Community Resources**. These initiatives address mental health/substance use, preventive health screenings, cancer, and vaccinations.

Patient Safety For Members

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

Member Rights and Responsibilities

The delivery of quality healthcare requires cooperation between Members, their Providers and Facilities and their healthcare benefit plans. One of the first steps is for Members and Providers to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members Rights and Responsibilities statement, available on Anthem's website FAQs. *Link:* **Member Rights and Responsibilities**

Continuity and Coordination Of Care

Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other healthcare 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 healthcare 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 healthcare professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral healthcare 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 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 the event a Member's care is being managed by an out-of-network Provider, an agreement to accept reimbursement at in-network rates is mandatory. If the out-of-network provider does not agree to in-network reimbursement rates, the Member will be transitioned to an in-network Provider. If the Member continues to access care from the out-of-network provider, services will not be payable.

In addition to the above, due to the requirements of the Federal Consolidations 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.

Performance Data

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

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

Overview of HEDIS

HEDIS *(Healthcare Effectiveness Data and Information Set)* is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of healthcare performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 96* measures across 6* domains:

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

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

For more information on HEDIS visit **Anthem.com**. Select **For Providers**, Select **Forms and Guides** (under the Provider Resources column). Scroll down and select **Forms and Guides**, then scroll down and select **HEDIS** in the Category drop down.

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 Members 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 the 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.

*Subject to Change
HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)
CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of healthcare. 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, but not limited to, National Heart, Lung and Blood Institute, American Diabetes Association, American Medical Association, American Academy of Pediatrics, and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions for our pediatric and adult membership. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. Anthem reviews the guidelines at least every year or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to **Anthem.com**. Select **For Providers** and, if needed **Select or Change a State (CA)** at the top right, then select **Policies, Guidelines and Manuals** from the horizontal menu under Provider Resources. Scroll to **Clinical Practice Guidelines** and select "**Download the Index**" or click on this link: **Clinical Practice 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 clinical practice guidelines.

Preventive Health Guidelines

Anthem considers prevention an important component of healthcare. Anthem adopts 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 **Anthem.com**. Select **For Providers**, then select **Policies, Guidelines and Manuals** from the horizontal menu under **Provider Resources**. Scroll to **Preventive Health Guidelines** and select "**Review the guidelines"** or click on this link: **Preventive Care Plans & 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.

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 worldviews) that shape personal and professional behavior.
- Develop understanding of others' needs, values and preferred means of having those needs met.
- Formulate culturally competent treatment plans.
- Understand how and when to use language support services, including formally trained interpreters and auxiliary aids and services, to support effective communication.
- Avoid use of family Members, especially minors, to act as interpreters for limited English proficient patients.

- Understand and adhere to regulations to support the needs of diverse patients, such as the Americans with Disabilities Act (ADA).
- Use culturally appropriate community resources as needed to support patient needs and care.

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

The My Diverse 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 an 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 healthcare to LGBTQIA+ patients.

  Improving the Patient Experience: Helps Providers identify opportunities and strategies to improve patient experience during a healthcare encounter.
- **Medication Adherence:** Helps Providers identify contributing factors to medication adherence disparities for diverse populations & learn techniques to improve patient-centered communication to support needs of diverse patients.
- **Moving Toward Equity in Asthma Care:** Helps Providers understand issues often faced by diverse patients with asthma & develop strategies for communicating to enhance patient understanding.
- **Reducing Healthcare Stereotype Threat (HCST):** Helps Providers understand HCST and the implications for diverse patients as well as the benefits of reducing HCST to both patients and practices, and how to do so.

Training Resources:

- **Cultural Competency Training (Cultural Competency and Patient Engagement)**: A training resource to increase cultural and disability competency to help effectively support the health and health care needs of your diverse patients*.
- **Caring for Diverse Populations Toolkit**: A comprehensive resource to help providers and office staff increase effective communication by enhancing knowledge of the values, beliefs, and needs of diverse patients. *

Anthem appreciates the shared commitment by Provides and Facilities to ensure Members receive culturally and linguistically appropriate services to support effective care and improved health outcomes. *Link to training resources referenced in the last two bullets: **EPHC Provider Toolkit** >scroll down towards the bottom of the page>Population Management.

Medical Record Standards

Anthem has standards that require Providers and facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential Member care and quality review. Anthem performs medical record reviews to assess whether network primary care physicians (PCPs) are compliant with current medical record standards. Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires Providers and facilities to comply with Anthem's standards for medical record documentation.

Medical record audits/reviews are performed annually on a percentage of randomly chosen PCPs contracted for Anthem's managed care products for Medicare Advantage networks and Commercial. For purposes of medical record audits/reviews, a PCP is defined as Family Medicine, General Medicine, Internal Medicine, Pediatrics and Obstetrics/Gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process.

In order to pass audits/reviews, an office must attain an overall score of 80% or greater on the medical record audit. If a PCP fails to meet Anthem's standard of 80%, a re-review is conducted within six (6) months. Should the PCP continue to score less than 80% on the medical record review, the PCP will be put on a corrective action plan that could result in termination from the network.

Medical Record Criteria
Medical records will be evaluated for the following criteria:

1. Every page in the record contains the patient's name or ID number.
2. Allergies/ No Known Drug Allergies ("NKDA") and adverse reactions are prominently displayed in a consistent location.
3. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials is noted.
4. The important diagnoses are summarized or highlighted.
5. A problem list is maintained and updated for significant illnesses and medical conditions.
6. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
7. History and physical exam identify appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
8. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or non-compliance to care plan).
9. Documentation of advance directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent part of the medical record for adult patients is encouraged.
10. Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes / reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing Provider reports.

11. Age-appropriate routine preventive services/risk screenings are consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

10| Credentialing & Recredentialing

Credentialing

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

Anthem's Credentialing Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards. All applicable practitioners and HDOs in Anthem's network within the scope of the Credentialing Program are required to be recredentialed at least every three (3) years unless otherwise required by applicable state contract or state regulations.

Additional information regarding Anthem's Credentialing Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference," available on Anthem.com. To access the Program Summary, go to **Anthem.com** Select **For Provider** and then **Credentialing** under **Join Our Network**, then select the **Program Summary** under the question, **Who do we Credential?** or click on this link: **Credentialing**.

Delegated Credentialing

Anthem delegates credentialing to medical groups that demonstrate compliance with Anthem established standards for credentialing, including all applicable accreditation standards and State and Federal regulatory requirements. The medical group's credentialing protocols must be in alignment with Anthem's Credentialing Program. Policies must include established credentialing system controls, policies and processes to protect and monitor data from unauthorized modification.

Compliance & Oversight
Anthem will perform or require the following as part of delegate credentialing medical group oversight:

- Pre-contractual audit prior to medical group delegation, including providing a description of the medical groups Credentialing system controls to protect and monitor data from unauthorized modifications.
- An initial audit (Post-Go-Live audit) within 90 – 120 calendar days after the contract effective date to measure compliance with Anthem's standards.
- An annual audit of the delegated medical group to ensure continued compliance with accreditation, State, and Federal regulations.
- A focused or off-cycle audit based specific activity.

- Sanctions or revocation of delegated UM duties for continued non-compliance with Anthem standards.
- Delegate development and implementation of a corrective action plan, when the medical group is non-compliant with Anthem standards.
- Delegate generated required reports as outlined in the delegation agreement that meet applicable regulatory requirements and accreditation standards.

11| Pharmacy

Pharmacy Benefit Coverage

Anthem applies utilization edits to specialty pharmacy drugs that are covered under a Members outpatient prescription drug benefit and utilizes clinical programs to minimize wastage and promote patient compliance. Dependent upon benefit coverage, Members can either pick medications up at their local retail pharmacy or have them delivered to their home or physician's office from our preferred specialty pharmacy.

Prior Authorization Of Pharmacy Benefits

Anthem reviews pharmacy utilization trends on a quarterly basis to identify medications that may be appropriate for our Prior Authorization of Benefits (PAB) program.

For each program, criteria and medical guidelines are established and approved by the Pharmacy and Therapeutics (P&T) Committee, which consists of practicing physicians and pharmacists. This external oversight ensures that the guidelines reflect community-prescribing standards, while adding to the value of the prescription drug benefit. If a medication is prescribed for "off-label" use in the treatment of an illness that is life threatening or chronic and debilitating, Anthem's policy is to allow coverage of such use of a medication with appropriate clinical evidence. Similarly, some drugs are best used after other effective and usually less expensive drugs have been tried and were unsuccessful (first-line therapy). These agents are noted as Step-Therapy products.

When a prescription for a Step-Therapy product is presented to the dispensing pharmacy, the online claims processor will search the patient's recent paid claims profile for first-line therapy. The claim will be processed automatically if recent first-line therapy is found. If a first-line therapy is not found, the claim will be rejected, and the dispensing pharmacist should call the Plan or the physician to discuss alternative prescription options.

Finally, a small number of drugs may be limited to use in certain age or gender groups and may have to be reviewed through the PAB process to determine benefit coverage.

Prescription Drug PAB requests should be faxed to the prescription drug plan prior authorization center at the fax number provided in *Section 2, Quick References*, under *Pharmacy Program*.
Click on this link: **Contact Information**

Urgent PAB requests are initially reviewed within 24 hours of receipt, and non-urgent PAB requests within two (2) business days, if the Prescription Drug Plan Prior Authorization Center has received all of required information. If additional information is required or the information submitted does not meet approval criteria, a final decision will be made within five (5) business days of the receipt of the request (72 hours for urgent requests).

Prescribing physicians are notified within 24 hours of decisions, while Members are notified within two (2) business days. In the event a PAB request is denied, a letter is sent to the prescribing physician explaining the medical reason(s) for the denial, and the name of the Anthem physician who issued the denial.

Information on the Anthem grievance and appeal process is included in the letters to the physician and Member. The Anthem PAB process is monitored regularly to secure timely outcomes. In emergency cases or life-threatening situations, a 72-hour supply of medication may be dispensed.

The Prescription Drug Plan Prior Authorization Center is responsible for processing initial PAB requests for Anthem Members. In some cases, requests are missing information that is required to make a decision. When this occurs, the prescribing physician may be asked to provide additional medical information in order to proceed with the review within 45 days. No decision will be made until additional information is received or the 45-day time period has expired.

If the requested information is not received, a determination will be made based on the information available, once the 45-day timeframe has expired. To obtain the status of a PAB request, contact the Prescription Drug Plan Prior Authorization Center at the phone number provided in *Section 2, Quick References,* under *Pharmacy Program*. *Click on this link:* **Contact Information**

Click here, to obtain a **Prescription Drug Prior Authorization Request Form**.

To obtain a list of PAB medications, contact the Prescription Drug Plan Customer Service Center at the phone number provided in *Section 2, Quick References*, under *Pharmacy Program*.
Click on this link: **Contact Information**

Under SB 866, for fully insured Members, regardless of the State where the Member resides, the State where the Provider is located, or the State where services are provided, delegated medical groups must notify the prescribing Provider within two (2) business days of the receipt of a completed Request Form that:

- The prescribing Provider's request is approved.
- The prescribing Provider's request is denied as not medically necessary or not a covered benefit.
- The prescribing Provider's request is denied for missing material information necessary to make a decision on the request.
- The patient is no longer eligible for coverage, or
- The request was not submitted on the required form.
- When additional information is submitted with a reconsideration of a previous denial, complete information is required for consideration.

Submissions can be submitted via a new SB866 form, or by providing a copy of the original submitted SB 866 form with the additional information needed for reconsideration. Reconsiderations will follow the same timeframe for completion as original submissions.

For operational ease, Anthem will also allow use of the CA Pharmacy Prior Authorization form for Members of all other funding types. For all other funding types, existing decision response times will remain.

Prior Authorization requests for prescription drugs will be considered approved, if Anthem or one of its delegated medical groups fails to review and respond within 72 hours of non-urgent requests and within 24 hours for urgent circumstances.

SB282

Under SB 282, approval timeframes above apply to the following types of prescription drug prior authorization requests:

- Formulary exception/non-formulary requests.

- Standard prescription drug prior authorization requests.
- Step-therapy override requests.
- Requests for an exception to Anthem's step therapy process for prescription drugs should be submitted in the same manner as a request for prior authorization for prescription drugs.
- Anthem will respond in the same manner as a request for standard prior authorization, for prescription drugs. (Delegated medical groups will be responsible for these requests per their existing processes).

Note: The uniform prescription drug prior authorization form, created by the DMHC and CDI must be used by Providers and insurers. *Link:* **Prescription Drug Prior Authorization Form**

Pharmaceutical Management

Based on consideration of published clinical studies, data from the Food and Drug Administration (FDA), community standards, and cost/benefit evaluation, Anthem's Formulary is a dynamic tool that promotes rational and evidence-based prescribing.

The Prescription Drug Formulary is a list of prescription drugs that are covered by Anthem. Coverage for most of these medications is available through the Members pharmacy benefit. For quality assurance and pharmacotherapy advancements, the Formulary is updated quarterly through the P&T Process (herein after referred to as the P&T). Formulary revision is based on objective evaluation of the efficacy, safety and value of reviewed medications. For copies of formularies, you can access the Anthem website at **Pharmacy Information for Providers** or call Provider Services at the phone number provided in *Section 2, Quick References*, under *Provider Services*. *Click on this link:* **Contact Information**

Quantity Supply Limits

Most pharmacy benefits allow for up to a 30-day supply of medication. This program defines a quantity limit based on FDA dosing recommendations. If a medical condition warrants a greater supply than what is recommended, the PAB will ensure access to a medically appropriate quantity. Prior to being dispensed, medications in this program require an internal review by Anthem.

For more information on the Quantity Supply Program, call the number listed on the Members ID card or access the Anthem website at **Pharmacy Information for Providers**.

Dose Optimization

The Dose Optimization Program, or dose consolidation, is an extension of the Quantity Supply Program and helps to increase patient adherence to drug therapies. Program Members work with the Member, the Members physician, and the pharmacist to replace multiple doses of lower-strength medications, where clinically appropriate, with a single dose of a higher-strength medication (only with the prescribing physician's approval). For more information on Dose Optimization, call the number listed on the Members ID card or access the Anthem website at **Pharmacy Information for Providers**.

Copayment Structure

Anthem offers a variety of pharmacy benefits that include Members out-of-pocket expenses, including deductibles, copayments and/or coinsurance. When using retail pharmacies or mail order services, Members pay a copayment at the point of sale. Specific copayment structures vary depending on the particular product under which the Member is covered.

Members may refer to their EOC for additional information regarding their plan's copayment structure. To verify eligibility and a Members pharmacy benefit, call the number listed on the Members ID card.

Other Drug Programs
Subject to benefit design, other pharmacy programs may apply to a Members prescription drug benefit. Direct Members may contact an Anthem Customer Service Representative or consult their Members EOC for an explanation of which programs apply to them.

Access To Non-Formulary Medications

The Drug Utilization Review (DUR) exception process provides access to most non-preferred and non-formulary medications, multi-source brands, therapeutic interchanges and Step-Therapy procedures for select benefit plans.

When the prescribing physician denotes "do not substitute" (DNS) or "dispense as written" (DAW) on the prescription, the pharmacist transmits the claim using the appropriate DUR code to allow adjudication of that claim. Select non-formulary medications are channeled through the PAB process, through which an internal review is required prior to being dispensed. For a copy of the formulary, access the Anthem website at **Pharmacy Information for Providers**, or call the number listed on the Members ID card.

Specialty Drug Fulfillment

Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified specialty drugs may require special handling, such as temperature-controlled packaging and overnight delivery.

Anthem dedicated teams manage our integrated specialty pharmacy benefit focused on managing the total healthcare needs of our Members. Our approach optimizes adherence and appropriateness of care, supports the physician/patient relationship and plan of care, reduces waste and total healthcare costs, includes comprehensive care management plan, utilization management (UM) and case management (CM), to ensure the Member is treated in the appropriate setting – outpatient hospital, clinic, doctor's office or at home.

In addition, specialty medications can be covered under both pharmacy and medical benefits. Subsequently, it is important to always verify Members eligibility and benefit coverage.

If Members have questions regarding specialty medications covered under their outpatient prescription drug benefit, refer them to the health plan website at **Anthem.com** or to the phone number on the back of their ID card.

If Providers have questions about specialty medications covered under the Members outpatient prescription drug benefit, they may call the Customer Service number on the back of the Members ID card or visit our website at **Pharmacy Information for Providers**.

Medical Benefit Coverage

If Members have questions regarding specialty medications covered under their medical benefit, Members should contact their assigned Customer Service Department at the phone number listed on the back of their Anthem ID Card or visit the Anthem website.

If Providers have questions about specialty medications covered under the Members medical benefit, they may call our Utilization Management (UM) Intake team at the phone number provided in *Section 2, Quick References*, under *Anthem HMO Co-Management Department*.
Click on this link: **Contact Information**

Select option #2 for eligibility, benefits, or claims and/or option #4 for specialty pharmacy Pre-authorization, or they may visit Availity to confirm eligibility, verify coverage or check claims status.

When benefits are provided for specialty drugs under the patient's medical benefits, they will not be provided under the patient's prescription drug benefit, if included.

Pre-Service Medical Review

For additional detail about our Anthem Medical Specialty Pharmacy Drug Pre-service Review Program, contact our Specialty Pharmacy Medical Management team directly at the phone or fax number provided in *Section 2, Quick References*, under *Pharmacy Program*. *Click on this link:* **Contact Information**

Pharmacy Home Program

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

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

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

The Pharmacy Home Program includes:

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

Criteria
A Member whose prescription Claims' history shows they meet the below inclusion criteria may be enrolled in the Pharmacy Home Program if:

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

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

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

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

Medical Specialty Pharmacy

Anthem's designated pharmacy for specialty medications administered in the office or outpatient hospital setting is CVS Specialty. Through this relationship, Providers can procure specialty drugs that are covered through a Members specialty pharmacy medical benefit. CVS Specialty provides fulfillment and distribution services to meet the needs of our Members and our Providers while alleviating the buy and bill process.

As of July 1, 2020, Providers are required to contact CVS Specialty's dedicated Anthem line to order certain specialty medications for commercial HMO Members. CVS Specialty can ship specialty drugs to a Members home, work, physician's office, or location of their choice, including more than 7,800 CVS pharmacy locations across the country. Providers should continue to submit non-capitated claims for the administration of the medication. Do not include charges for the medication itself.

IMPORTANT: Approval of and payment for the specified medications obtained through pharmacies other than CVS Specialty, will be denied.
Link: **Anthem Formulary/Drug Lists**

If Providers have questions about this process or about specialty drugs/Member benefits, call our Provider Services Department at the phone number provided in *Section 2, Quick References*, under *Provider Services*. *Click on this link:* **Contact Information**

Providers are required to comply with Anthem's programs related to the management of specialty medication expenses. Medical specialty medications administered in the office or in an outpatient hospital setting, must be procured through CVS Specialty effective July 1, 2020. This applies to certain specialty drugs covered under medical benefits for Commercial Members, where Anthem has financial risk. The HMO medical group will continue to be responsible for UM of specialty medications.

12| Anthem Health Insurance Marketplace (Exchanges)

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as Exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.

Updates about Anthem's ACA compliant health plans and the networks supporting these plans are published in Anthem's Provider newsletter and sent via Anthem's Email service. To sign up for Provider Communications for California, go to **Provider Communications**.

Click on this link to view or print a copy of the ACA Compliant Health Plans Quick Reference Guide: **Affordable Care Act (ACA) Compliant Health Plans Quick Reference Guide**.

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

Essential Community Providers

HMO medical groups who participate in the Exchange Network shall maintain a network that includes a sufficient geographic distribution of care, including Essential Community Providers ("ECP"), and other Providers available to provide reasonable and timely access to Covered Services for low-income, vulnerable, or medically underserved populations in each geographic area serviced by the HMO medical group. HMO medical group shall comply with other laws, rules and regulations relating to arrangements with ECPs, as applicable, including, those rules set forth at 45 C.F.R. § 156.235.

For purposes of demonstrating compliance, Anthem relies on the Covered California Consolidated Essential Community Provider List. The most up to date list is available on the Covered California website **Covered California**.

HMO medical group will respond to Anthem within 30 days of a request to demonstrate which ECPs they have Provider Agreements with and have made a good faith effort to contract with, within the geographic service area of the HMO medical group for Anthem Members.

Collection Practices
HMO medical group shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations.

Grace Period Status

Anthem shall provide HMO medical group with a Notice of Suspension prior to the start of the second month of the three-month grace period for an Individual Exchange Member receiving advance payments of the premium tax credit, for whom we have not received a premium. The notice shall inform the HMO medical group of the Members suspension of coverage during the second and third months of the Members grace period and shall include any other information required by State and Federal law.

This notice obligation only applies to HMO medical groups who have submitted claims to Anthem within the previous two months, any Provider who is an assigned Primary Care Provider (PCP) for that Member, and Providers who have an outstanding prior authorization to provide services to Members that receive Advance Premium Tax Credit.

Prescription Drugs

A current listing of Anthem's Exchange Formulary is available at **Anthem Formulary/Drug Lists**. The Exchange Formulary is the Individual Select Drug List.

Provider Directory

Anthem submits a listing of participating Providers in our Exchange networks to *Covered California* on a monthly basis. HMO medical groups shall ensure Provider demographic and participation status updates are shared with Anthem in accordance with the **Provider Responsibilities** section in this HMO Provider Manual, to ensure Anthem, in turn, provides up-to-date information to Covered California.

Disclosure Of Enrollee Costs

At a Members request, HMO medical group shall inform the Member of the amount the HMO medical group will pay for covered proposed non-emergency, out-of-network services, if there are any such services.

This disclosure is to allow Members, upon their request, the opportunity to act upon the HMO medical group's proposal or recommendation regarding (i) the use of a non-network Provider or facility, or (ii) the referral of a Member to a non-network Provider or facility for proposed non-emergency Covered Services.

Network Stability

Anthem has policies and practices that are designed to (i) to reduce the potential for disruption in our Provider networks, and (ii) to minimize the amount of uncertainty, disruption, and inconvenience to Members in the execution of the transition of care as required under State laws, rules and regulations in connection with any such disruption.

If Anthem experiences a termination of an HMO medical group or hospital that constitutes a block transfer as defined in Health and Safety Code § 1373.65 and Title 28, C.C.R. § 1300.67.1.3, Anthem provides Covered California with copies of the written notices Anthem proposes to send to affected Members, in compliance with the notice requirements of Health and Safety Code § 1373.65.

If Anthem experiences Provider network disruptions or other similar circumstances that make it necessary for Members to change health insurance plans or participating Providers, Anthem provides prior notice to Covered California and State Regulators, in accordance with advance notice, meeting, and other requirements set forth in applicable laws, rules, and regulations, including Insurance Code § 10199.1 and Health and Safety Code §§ 1367.23 and 1366.1.

In the event of a change in participating Providers or health insurance plans related to network disruption, block transfers, or other similar circumstances, Anthem requires HMO medical group to cooperate with Anthem and Covered California in planning for the orderly transfer of Members as necessary and as required under applicable laws, rules and regulations including, those relating to continuity of care.

In addition to posting information on our website, articles are published in our Provider Newsletter and sent via email to communicate information about Exchanges.

Important Reminders

Providers and facilities are able to confirm their participation status by using our “Find Care” tool. You are able to search by a specific Provider name or view a list of local in-network Providers and facilities using search features such as Provider specialty, zip code, and plan type.

Accessing the online Provider directory
The below link will take you to the **Find Care** page on Anthem’s webpage, to locate participating Providers **Find Care.**

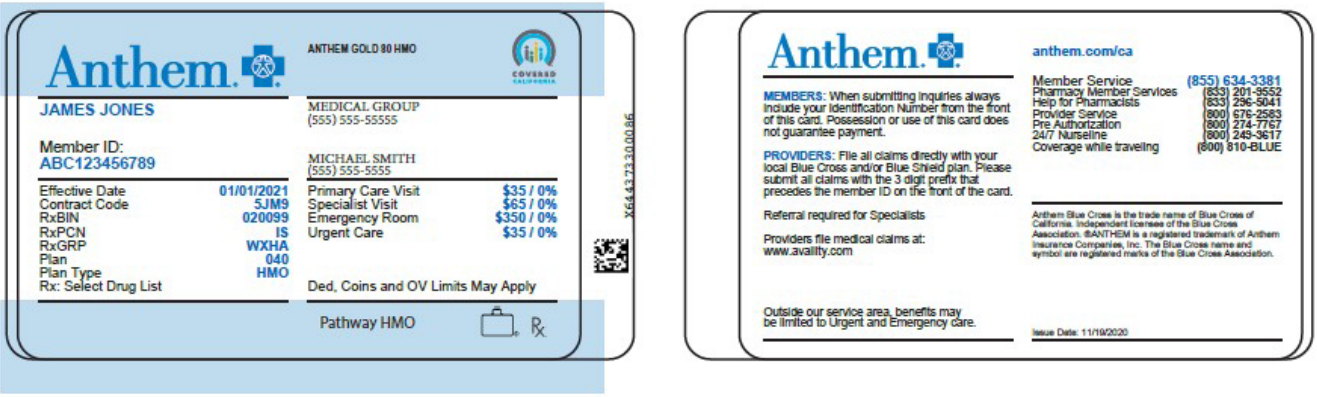
To locate On-Exchange Providers from the Find Care Home Page, scroll down to Search as a Guest by Selecting a “**Plan or Network**”, then choose **Type of Care – Medical** > State - CA > Type of Plan - **Medical Networks On-Exchange** > Plan/Network - **Pathway X-HMO Network**. Click on the **Continue** Button, then choose options: Type of Provider, Zip Code Location or Distance within a nearby zip code to begin your search.

Providers who have questions on their participation status are encouraged to contact Provider Experience at **Contact Us**.

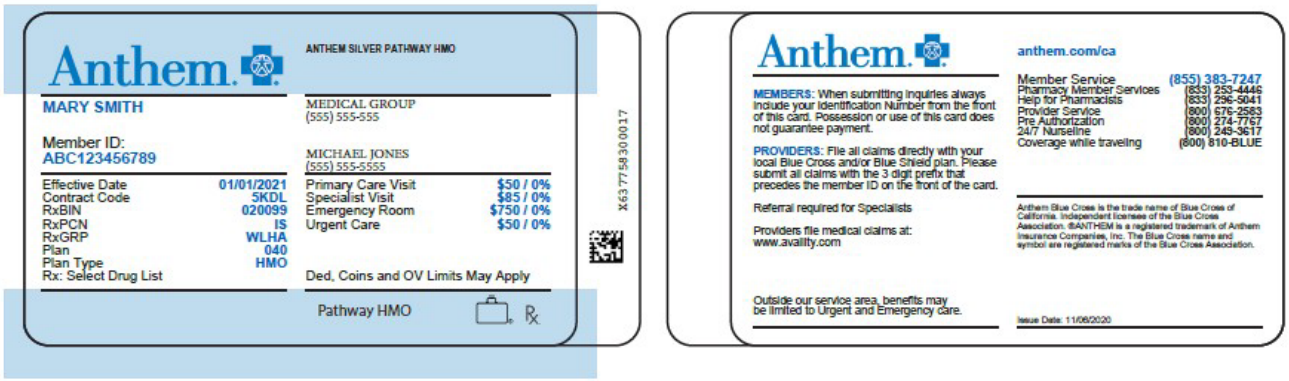
Provider demographic and participation status updates are shared with Anthem in accordance with the **Provider Responsibilities** section in this HMO Provider Manual. In turn, Anthem provides up-to- date information to Covered California.

Anthem Blue Cross Exchange ID Card Samples

On-Exchange



Off-Exchange



13| Grievance, Appeals & Disputes

Provider Dispute Process

The Department of Managed Health Care (DMHC) promulgated regulations known as the Claims Settlement Practices and Dispute Resolution Mechanism Regulations (Claims and Dispute Regulations), which can be found in ***Title 28* of the *California Code of Regulations, Sections 1300.71 and 1300.71.38*.** These regulations require Anthem and its Providers to establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve Provider disputes. The Federal Employee Program (FEP) is not within the jurisdiction of the DMHC. The Federal Employees Program (FEP) is governed by Federal regulations. To the extent required by claims and dispute regulations, the following sets forth your rights, responsibilities and related procedures for filing a Provider Dispute with Anthem. Unless otherwise provided herein, capitalized terms have the same meaning as those set forth in Sections ***1300.71* and *1300.71.38* of *Title 28* of the *California Code of Regulations***.

Dispute Resolution Process for Contracted Providers

Definition of a Contracted Provider Dispute
A contracted Provider Dispute is a Provider's written notice to Anthem challenging, appealing or requesting reconsideration of:

- a claim (or a multiple group of substantially similar claims that are individually numbered) that have been denied, adjusted, or
- a contract dispute (or multiple groups of substantially similar contractual disputes that are individually numbered); or
- a request for reimbursement of an overpayment of a claim. Each contracted Provider Dispute must contain, at a minimum, the following information: Provider's name, identification number, contact information and:
    a. If the contracted Provider Dispute pertains to an alleged denial of a claim, underpayment of a claim, or a request for reimbursement of an overpayment recovery made by Anthem on a claim, the following must be provided:
        - A clear identification of the disputed claim, including the claim number
        - The date of service
        - A clear explanation of the basis for which the Provider believes the payment amount should be
        - Requested additional information
        - Request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action
    b. If the contracted Provider Dispute is not about a claim, a clear explanation of the issue and the Provider's position on such issue, and
    c. If the contracted Provider Dispute involves an enrollee or group of enrollees:
        - Their name(s) and identification number(s)
        - A clear explanation of the disputed item, including the date of service and Provider's position on the dispute
        - Enrollees written authorization for the Provider to represent said enrollees

Submitting a Provider Dispute
Complete the **Provider Dispute Resolution Request** for each dispute and mail it to the address provided in *Section 2, Quick References,* under *Grievance and Appeals*. *Click on this link:* **Contact Information**

Time Period For Submission of Provider Disputes

a. Provider Disputes must be received by Anthem no later than 365 days from the "Anthem's'' action that led to the dispute, or

b. In the case of inaction, Provider Disputes must be received by Anthem no later than 365 days after the Provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.

c. Provider Disputes that do not include all required information, as set forth above, may be returned to the submitter for completion. An amended Provider Dispute, which includes the missing information, shall be submitted to Anthem within 30 working days of the returned receipt date.

Acknowledgment of Contracted Provider Disputes
Anthem will acknowledge receipt of all Provider Disputes within 15 working days of the date of receipt.

Provider Dispute Submission Requirements
Each contracted Provider dispute must contain, at a minimum, the following information:

- Provider's Name
- Provider's Tax Identification Number
- Contact Information and the following:

If The Contracted Provider Dispute…	Then The Following Must Be Provided
Pertains to an alleged denial of a claim, underpayment of a claim, or a request for reimbursement of an overpayment recovery made by Anthem on a claim	• A clear identification of the disputed claim the Date of Service • A clear explanation of the basis for which the Provider believes the payment amount should be • Requested additional information • Request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action
Is not about a claim	• A clear explanation of the issue • The Provider's position on the issue
Involves an enrollee or a group of enrollees	• The Members name(s) and Identification number(s) • A clear explanation of the disputed item, including the date of service and Provider's position on the dispute • Enrollee's written authorization for the Provider to represent the enrollee(s)

Status Inquiries
All inquiries regarding the status of a Provider Dispute must be directed to Anthem's Provider Care Department by "Type of Plan" at the telephone number listed on the back of the Members ID Card.

Filing Multiple Provider Disputes
You can use the **Provider Dispute Resolution Request Form** to address substantially similar multiple Provider claims, billing or contractual disputes. These disputes can be filed in batches as a single dispute, provided they are submitted in the following ways:

a. Sort Provider Disputes by similar issue
b. Provide cover sheet for each batch
c. Number each cover sheet
d. Provide a cover letter for the entire submission describing each Provider Dispute, with references to the numbered cover sheets
e. Claims may only be batched upon behalf of one (1) requesting party and are related to the same issue

Resolution Timeframe
Anthem will issue a written determination that states pertinent facts and explanation of the reasons for its determination within 45 working days after the date of original or amended receipt date of the Provider Dispute.

Past Due Payments
If the Provider Dispute involves a claim and it is determined, in whole or in part, in favor of the Provider, Anthem will pay any outstanding monies calculated to be due, as well as any interest and penalties required by law or regulation.

Following the Provider Dispute Resolution Process, if you continue to disagree with Anthem's decision, you may request a meet and confer, and then, if necessary, an Arbitration, pursuant to your Provider Agreement and the below Meet and Confer information.

Meet and Confer

All Provider Disputes must be processed through the Provider Dispute Resolution process prior to requesting a meet and confer conference. The following procedures are applicable to all meet and confer requests submitted to Anthem on or after the effective date of this Provider Manual.

Meet and Confer Submission Requirements
The party requesting the meet and confer (Requesting Party) provides all documentation and materials in support of its position. Any meet and confer request made by the medical group must contain the following information related to each Member that is the subject of the request:

- Members Name
- Members Anthem Identification Number
- Applicable Date(s) of Service
- A copy of the written determination that was made by Anthem on the dispute when it was submitted to the Anthem PDR process
- The Provider's expected reimbursement amount
- The manner in which the expected reimbursement amount was calculated by the Provider
- An explanation as to why the Provider disagrees with the Member claim determination made by Anthem during the PDR process.

Use the table below to obtain additional information that will be required based on the particular type of issue listed:

Issue	Required Information
Medical Necessity	The Members complete medical records for the date(s) of service in dispute
Timely Filing	Written proof that the claim was timely filed as outlined in the HMO Provider Manual
Lack of Authorization	Written proof of authorization
Coding Issues	Written documentation containing the required correct codes, together with proof that the corrected claim was submitted within the claims submission filing deadline based on the HMO Provider Manual

Submit meet and confer requests to the **Provider Experience Department** at the web address provided in Section 2, Quick References, under CA Contract Support. *Click on this link:* **Contact Information**

If your Provider Agreement with Anthem requires it, prior to filing an Arbitration Demand over one or more disputed issues, the parties shall meet and confer in an effort to resolve the dispute. Unless otherwise agreed to by both parties, the meet and confer will be handled based upon the exchange of written information related tom the disputed issue(s).

The party requesting the meet and confer (Requesting Party) shall provide all documentation and materials upon which it bases its position. Any meet and confer request made by the Provider shall, at a minimum, contain the following information related to each patient claim that is the subject of the meet and confer request:

1. Patient's name
2. Patient's Anthem Blue Cross identification number
3. Anthem Claim Number
4. Applicable date(s) of service
5. Copy of the written determination from Anthem (Provider Dispute Resolution process resolution)
6. Provider's expected reimbursement amount
7. The manner in which the expected reimbursement amount was calculated and
8. An explanation as to why the Provider disagrees with Anthem's patient claim determination (via the Provider Dispute Resolution Process)

For the particular types of issues set forth below, the following additional information shall be submitted in connection with a meet and confer request.

Medical Necessity
The patient's complete medical records for the date(s) of service in dispute including the clinical rationale for why services should be considered medically necessary, with additional supporting information.

Timely Filing
If a claim was denied based upon an alleged failure to submit a claim timely, written proof, in the form(s) set forth in this section of this Provider Manual that outline timely filing guidelines.

Link: **Timely Filing Acceptable Forms of Proof**. This link will direct you to the Provider Education and Training page. Scroll down and select **Supplemental Education Materials (SEMs)>SEM 21, Timely Filing Acceptable Forms of Proof**.

Lack of Authorization
If a claim was denied based upon a lack of authorization, written proof of authorization is required.

Coding Issues
If a claim was denied in whole or in part due to missing or incorrect revenue codes, CPT code(s) and/or HCPCS code(s), written documentation containing the required corrected codes, along with proof that the corrected claim was submitted within the claims submission filing deadline set forth in the Provider Agreement with Anthem is required.

Subject to any limitations that may be set forth in the Provider Agreement with Anthem, for purposes of the meet and confer, multiple claims may be “batched” or presented in the same manner previously described in this section.

If a satisfactory resolution is not reached through the meet and confer process, the Provider agrees to arbitrate the dispute, as outlined in the Provider Agreement. The Provider may only commence arbitration after the dispute has been contested through both the **Provider Dispute Resolution Process** and the **Meet and Confer Process**.

The Provider Dispute Resolution Process and the Meet and Confer Process shall not toll the running of the applicable statute of limitations for filing an Arbitration Demand. Therefore, the Provider or medical group is strongly encouraged to engage in the Provider Dispute Resolution and Meet and Confer processes in a timely manner.

Dispute Resolution, Mediation, and Arbitration

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider Agreement (the “Agreement”) or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth in the Agreement shall be exhausted prior to filing an arbitration demand. The following provisions set forth the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. To the extent possible, the language of the Agreement and the Provider Manual should be read together and harmonized if there are details in one not addressed in the other.

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

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

- **Pre-Arbitration Mediation and Selection and Replacement of Arbitrator(s)**
  Refer to the Agreement for invoking dispute resolution requirements, monetary thresholds of disputes (exclusive of interest, costs or attorney fees) that require a meeting to discuss and in effort to resolve or that require pre-arbitration mediation and selection of the mediator. In the

event of a dispute where the dispute resolution provision is invoked, the first step is for the complaining entity to provide written notice containing a detailed description of the dispute, all relevant underlying facts, a detailed description of the amount(s) in dispute and how they have been calculated and any other information in this Provider Manual describing the policy, procedure, process and so on that is being disputed.

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

- **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.

- **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. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Dispute Resolution and Arbitration Article of the Agreement, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request either a reasoned award or decision, or findings or 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 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.

  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.

- **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.

Member Grievance and Appeals Process

The Anthem grievance and appeal resolution process is designed to ensure that grievances and appeals from Members and their authorized representatives are processed and resolved in compliance with current State and Federal regulatory requirements and accreditation standards/ timeframes and as outlined in the Members EOC. Members or their authorized representatives have up to 180 calendar days from the date of an incident or dispute/denial to submit a grievance or appeal to Anthem unless otherwise specified in their Members EOC.

Anthem G&A is responsible for documenting, investigating, resolving, and responding to medical, behavioral health, benefit, and administrative grievance and appeals from Members and their authorized representatives.

California Health and Safety Code section 1368.01(b) requires health plan grievances to include the following:

The grievance system shall include a requirement for expedited plan review of grievances for cases involving an imminent and serious threat to the health of the patient, including, but not limited to, severe pain, potential loss of life, limb, or major bodily function. When the plan has notice of a case requiring expedited review, the grievance system shall require the plan to immediately inform enrollees and subscribers in writing of their right to notify the department of the grievance.

In order to allow us to immediately inform members of their right to notify the regulator of the grievance: For cases involving an imminent and serious threat to the health of an HMO patient (including, but not limited to severe pain and potential loss of life, limb, or major bodily function), Participating medical group/full-risk providers must inform Anthem within one hour not to exceed two if they receive a grievance from an Anthem HMO member.

The mailing address and fax number for G&A is provided in *Section 2, Quick References,* under *Grievance and Appeals*. *Click on this link:* **Contact Information**

Member Grievance Process and Terms Available To Members

Annual Certification of the Grievance Process

In compliance with ***California Health and Safety Code section 1368(a)(2); 28 CCR 1300.68(b)(6) and (7) and Knox Keene Act and Regulations***, Providers are required to comply with all the applicable laws and regulations and to cooperate with Anthem's administration of its grievance process. These regulations require Health Plans to ensure that PMGs and IPAs have grievance forms, a description of grievance procedures, and assistance in filing grievances readily available at each contracting Provider's

office, contracting facility, or Plan facility. It is important to implement processes to provide grievance forms and assistance to Anthem Members promptly upon request. Information on the process of submitting Member grievance and appeals, grievance forms, definitions and appeal rights, is located on Anthem's website at **Anthem Forms**. Go to **View by Topic** and click on the drop-down menu and select **Grievances & Appeals**, then select the desired resource link. They can also be found at the following link: **File a Complaint for Your Individual and Family Plan (anthem.com)**

Anthem requires that all contracted Providers submit an annual attestation certifying compliance with the grievance process.

To register for the course:

- Log in to Availity at **Availity.com**
- At the top of the Availity page, select **Payer Spaces>Anthem Blue Cross**
- On the Payer Spaces landing page, click **Access Your Custom Learning Center** from the **Applications** Tab,
- Search for the **Required Grievance Process/Form Course for Anthem Blue Cross Contracted Providers** using keyword **Grievance**.

Three times a year, (March, July and October) a provider education article regarding the requirements for Member Grievance will be sent by email and an article will be posted in the Plan's provider newsletter.

The annual attestation process will be sent, via email, in a survey to contracted providers, requiring providers to attest that they meet the requirement and to ensure that they have implemented processes to provide grievance forms and assistance to Members.

Clinical Appeals/Member Grievances

Clinical G&A addresses pre-service, urgent, concurrent, and post-service appeals for the following type of issues:

1. Medical necessity appeals.
2. Investigational/experimental (I/E) appeals.
3. Emergency services appeals (both in area and out of area).
4. Expedited appeals.
5. Benefit/coverage appeals.

Administrative G&A addresses administrative complaints, including, but not limited to complaints about Anthem and any of its processes, how a claim was paid, delay in receiving ID cards, and privacy complaints.

Initial Determination And Denial Notification Procedures

The initial determination for prospective, concurrent or retrospective healthcare services is made by the Members medical group. When a medical group denies a request for healthcare services, benefits or payment of a claim, the medical group must provide Members with a written denial letter explaining the rationale for the denial and how to file an appeal. The medical group is not delegated for the HMO grievance and appeal process, therefore, Member grievance and appeals received by the medical group must be forwarded to Grievance and Appeals within 72 hours along with medical group's supporting documentation.

Investigation of Appeals
Anthem G&A is responsible for obtaining the necessary medical information used in the initial denial, as well as any additional medical information deemed appropriate. G&A will send a request for a written response and medical records (on a *RFI* form) to the medical group.

The medical group is required to provide the requested information to G&A within seven (7) calendar days of the request, or sooner depending on the clinical urgency of the case. When G&A determines a medical group denial of a disputed healthcare service should be overturned, G&A will fax an overturn letter to the medical group specifying the reason for the overturn and with applicable criteria, benefit information or medical policy used to support the determination. The medical group has the opportunity to respond to a G&A overturn letter within the timeframe specified in the overturn letter (usually two (2) calendar days, unless urgent).

In addition, the medical group's Medical Director is offered the opportunity to discuss the case with an Anthem G&A Medical Director and/or a Department Manager or Director. If the medical group disagrees with the overturn, they should provide their rationale and any supporting documentation within the specified timeframe.

The case will be reviewed by Anthem physician reviewer(s) or a G&A Medical Director, who will make the final decision. In certain cases, the G&A Medical Director and/or a Department Manager or Director will contact the medical group's Medical Director to facilitate a mutually agreeable resolution on behalf of the Member.

If the medical group does not respond to the G&A overturn letter within the designated timeframe, the appeal is typically resolved in favor of the Member. Anthem will pay the claims for services that are by contract, the medical group's financial responsibility, and deduct payment from the medical group's future capitation.

After G&A has completed the appeal review, a written statement of its resolution is sent to the Member and Provider within 30 calendar days of the Anthem receipt date. If G&A upholds the medical group denial, the resolution letter will include a description of further appeal options.

Expedited Appeals

Members have the right to request an expedited appeal for urgent conditions. An appeal will be expedited if the Members case involves an imminent threat to their health, including severe pain, the potential loss of life, limb or major bodily function. A request for response and records will be faxed to the medical group. The medical group is required to fax the information to G&A within 24 hours of the request. Expedited appeals must be resolved within 72 hours of the Anthem receipt date and time. The Member and Provider are notified verbally of the decision within 72 hours, followed by written notification to the Member and Provider within three (3) calendar days of the Anthem receipt date.
For expedited appeals related to concurrent inpatient care in a facility or home healthcare services, the Anthem G&A physician reviewer will be available to discuss the case with the treating practitioner and medical group by telephone, and will render a verbal decision, as appropriate. Verbal notification will be followed by written notification within 24 hours

Written notification is faxed to the facility and to the treating practitioner within 24 hours of verbal notification. Written notification is mailed to the Member within three (3) calendar days of the Anthem receipt date.

The written notice will include the decision, rationale, and applicable review criteria used in the decision, and if denied, a description of further appeal rights, such as the Members right to request an Independent Medical Review (IMR).

Emergency Care and Services

Emergency care is covered, in accordance with the terms and conditions of the Members EOC, and the requirements set forth by the Health and Safety Code related to emergency services. The timeframe for resolution of appeals related to payment of claims for emergency services is 30 calendar days from the Anthem receipt date.

Denial of Emergency Services/Lack of Authorization

When a medical group denial is based solely on lack of authorization, G&A will overturn the medical group denial and send an approval letter to the Member, with a copy to the medical group. The charges that are, by contract, the medical group's financial responsibility, are paid by Anthem and deducted from the medical group's future capitation. ***California SB 1832*** prohibits the denial of emergency services based solely on lack of prior authorization and, therefore, the medical group will be held financially liable for an inappropriate denial.

Medical Necessity Denials

When a medical group denial is based on lack of medical necessity, the designated G&A reviewer presents the case, with the medical records, to the Physician Reviewer for review and determination. When appropriate, a like-specialty reviewer will be obtained. When the physician reviewer determines that a denial should be overturned, an overturn letter is sent to the medical group explaining the rationale for the overturn. If no response is received from the medical group within two (2) calendar days, the appeal is resolved in favor of the Member.

If the medical group disputes the Physician Reviewers determination within the two (2) day timeframe, the case is sent to another non-subordinate Physician Reviewer who did not participate in the previous review for a final determination.

Member Remedial Action (Disenrollment Process)

Anthem G&A is responsible for addressing remedial action requests from medical groups. G&A analysts perform the initial screening of issues, obtain the necessary documentation for each case considered for remedial action, and oversee the review process until resolved. Because of the potential significance of the issues involved, substantial documentation is required for each case.

Remedial action requests are decided based on the type and severity of the issue and its impact on the parties involved, the adequacy and completeness of the supporting documentation, and the terms and conditions of the Members EOC.
Anthem notification to Members of any due process activity or Member remedial action must be provided by written notice, certified mail/return receipt, and delivered no less than 30 calendar days in advance of the due process activity or remedial action effective date. These written notifications must clearly explain the Members right of response and rebuttal. The Member must have the opportunity to respond to alleged causes of action directly to G&A, prior to its determination and implementation of any remedial action. Remedial action letters must offer appropriate dispute resolution mechanisms.

Background and Scope

State and Federal legislation enables HMOs to offer managed medical care to their Members. The joint responsibilities between the HMO, its healthcare Providers, and its Members are defined in the contracts between the parties. Failure to uphold these responsibilities may jeopardize the ongoing relationships between the parties and interfere with the provision of proper medical care. In accordance with the terms and conditions of the Members EOC*,* Anthem Members are obligated to:

- Be as accurate and complete as possible when providing information about their medical history or condition.
- Cooperate in following instructions by those providing their healthcare.
- Read and cooperate with the instructions outlined in the Members EOC.
- Ask for clarification about any aspect of their healthcare or benefits they do not fully understand.
- Keep scheduled appointments or give adequate notice of delay or cancellation.
- Treat those caring for them with respect and courtesy.

In those cases where Members do not meet their obligations, as stated above, the remedial actions available to Anthem are progressive notification, involuntary medical group transfer, probation, and disenrollment from the plan.

Definitions

Progressive Notification
A series of three or more notification letters sent by the medical group to a Member detailing the cause of action and requesting that the Member respond and/or cooperate with the medical group to remedy the applicable issue within a specific timeframe.

Upon notice from the medical group that a Member has failed to correct the issue or behavior after receiving the third notification letter, the medical group may submit a request for remedial action to Anthem, along with supporting documentation. Medical care should not be delayed during this review.

Member Remedial Action (Disenrollment Process/Involuntary Member Transfer)
Anthem G&A is responsible for addressing Member-related remedial action requests from medical groups. G&A analysts perform the initial screening of issues, obtain the necessary documentation for each case considered for remedial action, and oversee the review process until resolved. Because of the potential significance of the issues involved, substantial documentation is required for each case. G&A addresses remedial action requests based on the type and severity of the issue and its impact on the involved parties, the adequacy and completeness of the supporting documentation, and the terms and conditions of the Members EOC.

Upon determining that a Member has failed to correct an issue or behavior that jeopardizes the ability to maintain a positive patient physician relationship, the medical group may make a request to the Anthem G&A department to reassign the Member to a different Provider practice. This notification to Anthem should include a description of the Member behavior that caused the failure, all attempts the physician/medical group made to resolve the issue, and any supporting documentation. Anthem G&A department makes the decision to reassign a Member to a different medical group only when G&A determines this is an appropriate resolution. The PMG retains responsibility for the care of the Member until the transfer becomes effective.

The mailing address and fax number for G&A is provided in *Section 2, Quick References,* under *Grievance and Appeals*. *Click on this link:* **Contact Information**

Patient Responsibility Agreement

The participating Provider may not bill the Member for care or services denied for payment based on medical necessity, unless the Member signs a waiver letter (separate from any waiver information on any admission form) accepting liability during their stay, for services denied prospectively or for days of acute care beyond those approved as medically necessary. The waiver form must be separate from an admission form, signed prior to rendering services and must include an estimate of the cost of services.

Link: **Member (Patient) Responsibility Agreement - Waiver Form**. Type **Member Responsibility Agreement** in the Search Anthem.com bar. In the left margin, under Narrow your results, choose Providers.

Member Quality of Care/Quality of Service Investigations

Oversight
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 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/QOS 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 final determination of the severity of the QOC/QOS matter. If the QOC/QOS 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. In most instances, this information is protected by Peer Review confidentiality which will be maintained during Anthem's QOC/QOS review.

Corrective Action Plans ("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 completion of corrective action plans by the noticed deadline 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

Grievance and Appeal 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 also reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.