Anthem Blue Cross and Blue Shield

# Virginia Professional Provider Manual

Effective March 1, 2025

Anthem
And Its Affiliate HealthKeepers, Inc.



VABCBS-CM-PM-072981-24 | v1 11262024

# Table of Contents

# Introduction and Guide to Manual

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

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

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

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

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

**Provider and Facility**

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

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

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

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

**Capitalization**

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

## Future Updates

Anthem is committed to providing contracted Providers with an accurate and up-to-date Professional Provider Manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, Anthem will make every effort to distribute updated documentation in the next manual update. In those instances when Anthem determines that

information in this manual differs from that in the Agreement, the Agreement will take precedence over the Manual.

The information in this manual applies to Anthem Commercial networks. To find manuals for all Anthem plans by going to the Provider Manual Library at **anthem.com**. From Menu, select **For Providers**, select **Policies, Guidelines & Manuals**, if needed select **Virginia**, then scroll down and select **Download the Manual** under **Provider Manual** and select the appropriate provider manual.

# Legal and Administrative Requirements

## Fair Business Practices Act (FBPA)

### § 38.2-3407.15. Ethics and Fairness in Carrier Business Practices Act

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in § 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (§ 38.2-5800 et seq.) or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection I, every provider contract entered into by a carrier shall contain specific

provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within 40 days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

    a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

    b. The claim was submitted fraudulently. Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within 30 days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 7. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under § 38.2-3407.1 or 38.2-4306.1, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within 60 days thereafter.

4.

    a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, downcoding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and

conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or downcodes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (1) disclose in its provider contracts or on its website the specific bundling and downcoding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (2) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and downcoding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within 10 business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care services are medically necessary and a covered benefit, unless:

   a. The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized;

   b. The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person's eligibility status; or

   c. During the post-service claims process, it is determined that the claim was submitted fraudulently.

6. In the case of an invasive or surgical procedure, if the carrier has previously authorized a health care service as medically necessary and during the procedure the health care provider discovers clinical evidence prompting the provider to perform a less or more extensive or complicated procedure than was previously authorized, then the carrier shall pay the claim, provided that the additional procedures were (i) not investigative in nature, but medically necessary as a covered service under the covered person's benefit plan; (ii) appropriately coded consistent with the procedure actually performed; and (iii) compliant with a carrier's post-service claims process, including required timing for submission to carrier.

7. No carrier shall impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on

the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) 12 months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least 30 days in advance of any retroactive denial of a claim.

8. Notwithstanding subdivision 7, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.
9. No provider contract shall fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy, or statement as to the manner in which claims will be calculated and paid that is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules, and exhibits thereto and any policies (including those referred to in subdivision 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.
10. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider's intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.
11. In the event that the carrier's provision of a policy required to be provided under subdivision 9 or 10 would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider.
12. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.
13. Every carrier shall include in its provider contracts a provision that prohibits a provider from discriminating against any enrollee solely due to the enrollee's status as a litigant in pending litigation or a potential litigant due to being involved in a motor vehicle accident. Nothing in this subdivision shall require a health care provider to treat an enrollee who has threatened to make or has made a professional liability claim against the provider or the provider's employer, agents, or employees or has threatened to file or has filed a complaint with a regulatory agency or board against the provider or the provider's employer, agents, or employees.

C. If the Commission has cause to believe that any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Commission may submit information to the Board of Medicine or the Commissioner of Health for action. Prior to such submission, the Commission may provide the provider with an opportunity to cure the alleged violations or provide an explanation as to why the actions in questions were not violations. If any provider has engaged in a pattern of potential violations of subdivision B 13, with no corrective action, the Board of

Medicine or the Commissioner of Health may levy a fine or cost recovery upon the provider and take other action as permitted under its authority. Upon completion of its review of any potential violation submitted by the Commission or initiated directly by an enrollee, the Board of Medicine or the Commissioner of Health shall notify the Commission of the results of the review, including where the violation was substantiated, and any enforcement action taken as a result of a finding of a substantiated violation.

D. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and 2 in the performance of its provider contracts.

E. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier's compliance is rendered impossible due to matters beyond the carrier's reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

F. Any provider who suffers loss as the result of a carrier's violation of this section or a carrier's breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier's gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained. Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

G. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

H. This section shall apply only to carriers subject to regulation under this title.

I. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

**§ 38.2-3407.15:2. Carrier contracts; required provisions regarding prior authorization**

A. As used in this section, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Prior authorization" means the approval process used by a carrier before certain drug benefits may be provided.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Supplementation" means a request communicated by the carrier to the prescriber or his designee, for additional information, limited to items specifically requested on the applicable prior authorization request, necessary to approve or deny a prior authorization request.

B. Any provider contract between a carrier and a participating health care provider with prescriptive authority, or its contracting agent, shall contain specific provisions that:

1. Require the carrier to, in a method of its choosing, accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards;
2. Require that the carrier communicate to the prescriber or his designee within 24 hours, including weekend hours, of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation;
3. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;
4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;
5. Require that if the prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;
6. Require that prior authorization approved by another carrier be honored, upon the carrier's receipt from the prescriber or his designee of a record demonstrating the previous carrier's prior authorization approval or any written or electronic evidence of the previous carrier's coverage of such drug, at least for the initial 30 days of a Member's prescription drug benefit coverage under a new health plan, subject to the provisions of the new carrier's evidence of coverage;
7. Require that a tracking system be used by the carrier for all prior authorization requests and that the identification information be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request;
8. Require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier be made available through one central location on the carrier's website and that such information be updated by the carrier within seven days of approved changes;
9. Require a carrier to honor a prior authorization issued by the carrier for a drug, other than an opioid, regardless of changes in dosages of such drug, provided such drug is prescribed consistent with U.S. Food and Drug Administration-labeled dosages;

10. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless if the covered person changes plans with the same carrier and the drug is a covered benefit with the current health plan;
11. Require a carrier, when requiring a prescriber to provide supplemental information that is in the covered individual's health record or electronic health record, to identify the specific information required;
12. Require that no prior authorization be required for at least one drug prescribed for substance use disorder medication-assisted treatment, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, and (iii) the drug is prescribed consistent with the regulations of the Board of Medicine.
13. Require that when any carrier has previously approved prior authorization for any drug prescribed for the treatment of a mental disorder listed in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, no additional prior authorization shall be required by the carrier, provided that (i) the drug is a covered benefit, (ii) the prescription does not exceed the FDA-labeled dosages, (iii) the prescription has been continuously issued for no fewer than three months, and (iv) the prescriber performs an annual review of the patient to evaluate the drug's continued efficacy, changes in the patient's health status, and potential contraindications. Nothing in this subdivision shall prohibit a carrier from requiring prior authorization for any drug that is not listed on its prescription drug formulary at the time the initial prescription for the drug is issued; and
14. Require a carrier to honor a prior authorization issued by the carrier for a drug regardless if the drug is removed from the carrier's prescription drug formulary after the initial prescription for that drug is issued, provided that the drug and prescription are consistent with the applicable provisions of subdivision 13.
15. Require a carrier, beginning July 1, 2025, notwithstanding the provisions of subdivision 1 or any other provision of this section, to establish and maintain an online process that (i) links directly to all e-prescribing systems and electronic health record systems that utilize the National Council for Prescription Drug Programs SCRIPT standard and the National Council for Prescription Drug Programs Real Time Benefit Standard; (ii) can accept electronic prior authorization requests from a provider; (iii) can approve electronic prior authorization requests (a) for which no additional information is needed by the carrier to process the prior authorization request, (b) for which no clinical review is required, and (c) that meet the carrier's criteria for approval; and (iv) links directly to real-time patient out-of-pocket costs for the office visit, considering copayment and deductible, and (v) otherwise meets the requirements of this section. No carrier shall (a)impose a fee or charge on any person for accessing the online process as required by this subdivision or (b)access, absent provider consent, provider data via the online process other than for the enrollee. No later than July 1, 2024, a carrier shall provide contact information of any third-party vendor or other entity the carrier will use to meet the requirements of this subdivision or the requirements of Section 38.2-3407.15:8to any provider that requests such information. A carrier that posts such contact information on its website shall be considered to have met this requirement; and
16. Require a participating health care provider, beginning July 1, 2025, to ensure that any e-prescribing system or electronic health record system owned by or contracted for the provider to maintain an enrollees health record has the ability to access, at the point of prescribing, the

electronic prior authorization process established by a carrier as required by subdivision 15 and the real-time patient-specific benefit information, including out-of-pocket costs and more affordable medication alternatives made available by a carrier pursuant to Section 38.2-3407.15:8. A provider may request a waiver of compliance under this subdivision for undue hardship for a period specified by the appropriate regulatory authority with the Health and Human Resources Secretariat.

C. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

D. This section shall apply with respect to any contract between a carrier and a participating health care provider, or its contracting agent, that is entered into, amended, extended, or renewed on or after January 1, 2016.

E. Notwithstanding any law to the contrary, the provisions of this section shall not apply to:

1. Coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE);
2. Accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverages;
3. Any dental services plan or optometric services plan as defined in § 38.2-4501; or
4. Any health maintenance organization that (i) contracts with one multispecialty group of physicians who are employed by and are shareholders of the multispecialty group, which multispecialty group of physicians may also contract with health care providers in the community; (ii) provides and arranges for the provision of physician services by such multispecialty group physicians or by such contracted health care providers in the community; and (iii) receives and processes at least 85 percent of prescription drug prior authorization requests in a manner that is interoperable with e-prescribing systems, electronic health records, and health information exchange platforms.

Section 38.2-3407.15:7. Carrier provision of certain information.

A. As used in this section:

"Carrier" has the same meaning as provided in Section 38.2-3407.15.

"Enrollee" has the same meaning as provided in Section 38.2-3407.10.

"Pharmacy benefits manager" has the same meaning as provided in Section 38.2-3465.

"Provider" has the same meaning as provided in Section 38.2-3407.10.

B. Beginning July 1, 2025, any carrier or its pharmacy benefits manager shall provide real-time patient-specific benefit information to enrollees and contracted providers for the office visit, including any out-of-pocket costs and more affordable medication alternatives or prior authorization requirements, and shall ensure that the data is accurate. Such cost information data shall be available to the provider at the point of prescribing in an accessible and understandable format, such as through the provider's e-prescribing system or electronic health record system that the carrier or pharmacy benefits manager or its designated subcontractor has adopted that utilizes the National Council for Prescription Drug Programs Script standard and the National Council for

Prescription Drug Programs Real Time Benefit Standard from which the provider makes the request.

## Virginia Professional Provider Manual

The Virginia Professional Provider Manual, “Legal and Administrative Requirements” section is amended by the addition of the following language at the end of the section:

**“Federal Consolidated Appropriations Act (CAA) “Gag Clause”**

The **Consolidated Appropriations Act (CAA), specifically, Section 201: INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION.** The CAA is a federal act that contains legal and regulatory requirements imposed on health plans and providers, including but not limited to, provisions known as “gag clauses”.

The term *“Provider”* as used in this section refers to a Participating Provider of Plan regardless of the defined name of your provider type (professional or facility) in your provider agreement or if you are a sole proprietor or a “provider group” such as a medical group, independent practice association or other similar group of providers.

Plan will follow the requirements of the CAA, including restrictions on gag clauses.

The CAA provides, in part, the following:

Increasing transparency by removing gag clauses on price and quality information.

(a) Increasing price and quality transparency for plan sponsors and group and individual market consumers.

(1) Group health plans. A group health plan or health insurance issuer offering group health insurance coverage may not enter into an agreement with a health care provider, network or association of providers, third-party administrator, or other service provider offering access to a network of providers that would directly or indirectly restrict a group health plan or health insurance issuer offering such coverage from:

(A) providing provider-specific cost or quality of care information or data, through a consumer engagement tool or any other means, to referring providers, the plan sponsor, enrollees, or individuals eligible to become enrollees of the plan or coverage;

(B) electronically accessing de-identified claims and encounter information or data for each enrollee in the plan or coverage, upon request and consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990, including, on a per claim basis

(i) financial information, such as the allowed amount, or any other claim-related financial obligations included in the provider contract;

(ii) provider information, including name and clinical designation;

(iii) service codes; or

(iv) any other data element included in claim or encounter transactions; or

(C) sharing information or data described in subparagraph (A) or (B), or directing that such data be shared, with a business associate as defined in section 160.103 of title 45, Code of Federal Regulations (or successor regulations), consistent with the privacy regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996, the amendments made by the Genetic Information Nondiscrimination Act of 2008, and the Americans with Disabilities Act of 1990.

Any provision in the provider agreement and/or the provider manual that is inconsistent with the requirements of Section 201: INCREASING TRANSPARENCY BY REMOVING GAG CLAUSES ON PRICE AND QUALITY INFORMATION, of the CAA, shall be deemed null and void.

## Provider Data Verification Required

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

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

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

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

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

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

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

## Affiliates

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

To view a current listing of Anthem Affiliates visit anthem.com, select **For Providers**, select **Forms and Guides** (under the Provider Resources column), if needed **Select Virginia**, then scroll down and select **Contracting & Updates** in the Category drop down and select **Affiliated Companies**.

## 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 Guide** (under the Provider Resources column), if needed select **Virginia**, then scroll

down and select **Administrative Policies** in the Category drop down and select **Clinical Data Sharing.**

## Coordination of Benefits

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

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

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

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

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

### When filing Coordination of Benefits Claims on paper submission

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

## Financial Institution/Merchant Fees

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

## Insurance Requirements

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

## Misrouted Protected Health Information (PHI)

Providers 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, email, 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.

## Open Practice

Provider shall give Anthem thirty (30) 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 Accessibility

Provider agrees to make necessary and appropriate arrangements to ensure the availability of Health Services to Members.

| | PCP | Specialists | BH |
|---|---|---|---|
| Preventive Care | 60 calendar days | | |
| Urgent Care | 24 hours | 24 hours | 24 hours |
| Routine Care | 10 business days | 30 calendar days | |
| Initial Routine | | | 10 business days |
| Follow-up Routine | | | 30 calendar days |
| Non Life-Threatening Emergency Needs | | | 6 hours, or Member redirected to 911, ER or 24 hour crisis services as appropriate |
| After Hours Access | Members must have access to care 24 hours a day, 7 days a week, 365 days a year. Must have arrangement for after-hours care to provide 24 hour coverage for Members by a network provider during non-business office hours. Compliance requires that a recording or live person directs callers to Urgent Care, 911, the ER, or connects the call to the caller's doctor or the doctor on call. In addition to these measures, but not in place of them, the messaging can give callers the option of contacting their health care practitioner (via transfer, cell phone, pager, text, email or voicemail) or an opportunity to ask for a call back for urgent questions or instructions. | | |

## Provider 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 Responsibilities

Providers are responsible for notifying Anthem when changes occur within the Provider practice. 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

## Referring to Non-Participating Providers

Anthem's mission is to provide affordable quality healthcare benefits to its Members. Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers 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 are reminded that pursuant to their Agreement with Anthem they are generally required to refer Members to other Network/Participating Providers and Facilities. Providers 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 must refer to a non-participating provider. For additional information on in-network and out-of-network referrals, Providers 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, and Providers are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

**Encounter Data for Risk Adjustment Purposes**

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

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

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

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

**RADV Audits**

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the Members diagnosis data that was previously submitted by health plans. These audits are typically performed once a year. If the health plan selected by HHS to participate in a RADV audit, the health plan and the Providers 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. For example, in accordance with the guidelines, it is important for physicians to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the Provider code to the highest level of specificity which includes fully documenting the patient's diagnosis.

**Medical Record Documentation Requirements**

Medical records significantly impact risk adjustment because:

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

Because of this, the Provider plays 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

# Digital Applications

## Anthem Provider Website

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

Anthem designed the provider public website to make navigation easy and more useful for Providers and Facilities.

The website holds timely and important information to assist providers when working with Anthem. Go to **anthem.com** and Select **For Providers** from the horizontal menu. On the Providers Overview page, pick Virginia and choose content available.

Providers and Facilities can also sign-up for the Network eUpdates to be notified when a newsletter is published. Newsletters are designed to educate Providers, Facilities and their staff on updates and notification of changes. To sign up go to **anthem.com**, Select **For Providers**, **Providers Overview** and **Virginia**. Scroll down and select **Read the Most Recent Provider News**. On the Provider Communications page select **Subscribe to Email**.

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

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

## Online Provider Directories 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 using search features such as provider specialty, zip code, and plan type.

### Online Provider Directory

Accessing the Online Provider Directory:

- Go to **anthem.com**
- Select the **Find Care** link at the top right of the page. Select **a state**.

**Note:** The Member's Network Name should be on the lower right corner of the front of the Member's ID card.

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

To help ensure Members are directed to Providers within their specific Network, utilize the Online Provider Directory one of the following ways:

- **Search as a Member**: Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
- **Search as a Guest**: Select **Basic Search as Guest**.

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

**Updating Demographic Data with Anthem**

It is critical that Members receive accurate and current data related to Provider availability. Providers must notify Anthem of any demographic changes. All requests must be received thirty (30) days prior to change/update. Any requests received with less than thirty (30) days' notice may be assigned a future effective date. Contractual terms may supersede effective date request.

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

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

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)**
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges
- Languages Spoken
- License Number
- Name Change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice*
- Specialty
- Tax Identification Number (TIN) (must be accompanied by a W-9 to be valid)
- Termination of Provider Participation Agreement
- Web Address

### Methods for updating provider data

Use the Provider Data Management (PDM) application on Availity Essentials to verify and initiate care provider demographic change requests for all 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. If any roster data updates require credentialing, your submission will be routed appropriately for further action.

The resources for this process are listed below and available on our website. Visit **anthem.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

### Proactive Monitoring and Correction Program of Provider Data

Anthem utilizes a proactive monitoring and correction program to further ensure provider directory data is accurate. The program uses technology and various data sources to confirm the status and accuracy of the directory data. Providers may be removed from the directory when it is determined the provider data is inaccurate.

## Availity Essentials

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

**Availity Essentials is available to all Providers and Facilities:**

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

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

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

**Additional methods of digital 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 Messaging 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 Payor:** 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 payor specific educational materials.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services
- **Patient360:** A robust picture of a Member's health and treatment history.
- **Preference Center:** A resource for Providers and Facilities to share correspondence preferences related to specific transactions, for example, prior authorization decision letters and PCPs patient event notifications.
- **Provider Digital RFAI Progress Dashboard:** For Providers and Facilities enrolled in Medical Attachments and using the Attachments Dashboard to receive digital notifications when additional documentation is needed to process Claims, use this Dashboard to show your organization's attachment performance.
- **Provider Online Reporting:** access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Provider Enrollment:** Submit an online request to join Anthem's provider network.
- **Remittance Inquiry**: View imaged copies of the paper Anthem remits up to twenty four (24) months in the past.

### Getting Started and Availity Training

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

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

### Availity Essentials Training for Anthem Specific Tools

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

### Organization Maintenance

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

### Support

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

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

## Provider and Facility Digital Guidelines

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

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

Digital guidelines establish the standards for using secure digital Provider platforms (websites) and applications when transacting business with Anthem. These platforms and applications are accessible

to both participating and nonparticipating Providers and Facilities and encompass Availity.com, electronic data interchange (EDI), electronic medical records (EMR) connections and business-to-business (B2B) desktop integration.

The Digital Guidelines outline the digital/electronic platforms Anthem has available to participating and nonparticipating Providers and Facilities who serve its members. The expectation of Anthem is based on our contractual agreement that Providers and Facilities will use these digital platforms and applications, unless otherwise mandated by law or other legal requirement.

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

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

Digital guidelines available through Availity Essentials include:

- Acceptance of digital ID cards
- Eligibility and benefit inquiry and response
- Prior authorization submissions including updates, clinical attachments, authorization status, and clinical appeals
- Claim submission, including attachments, Claim status and
- Remittances and payments
- Provider enrollment
- Demographic updates

Additional digital applications available to Providers and Facilities include:

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

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

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

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

**Section 1: Accepting digital ID cards**

As our members transition to digital Member ID cards (in some markets), Providers and Facilities may need to implement changes in their processes to accept this new format. Anthem expects that

Providers and Facilities will accept the digital version of the Member identification card in lieu of a physical card when presented. If Providers and Facilities require a copy of a physical ID card, Members can email a copy of their digital card from their smartphone application, or Providers and Facilities may access it directly from Availity Essentials through the Eligibility and Benefits Inquiry application.

**Section 2: Eligibility and benefits inquiry and response**

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

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

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

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

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

management software and some EMR software. Contact Availity for available vendor integration.

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

Claim submissions status and Claims payment disputes

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

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
  - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.
  - 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).
- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Anthem supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
  - The Claims & Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - Claim Status application enables Providers and Facilities to access online Claim status. Access the Claim payment dispute tool from Claim Status. Claims Status also enables online Claim payment disputes in most markets and for most Claims. It is the expectation of Anthem that electronic Claim payment disputes are adopted when and where it is integrated.
- Provider desktop integration via B2B APIs:
  - Anthem has also enabled real-time access to Claim status via APIs, which can be directly integrated within participating vendor's practice management software, revenue cycle management software and some EMR software. Contact Availity for available vendor integration.

Claim attachments

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

- EDI transaction: X12 275 – patient information, including HL7 payload attachment:
  - Anthem supports the industry standard X12 275 transaction for electronic transmission of supporting Claims documentation including medical records via the HL7 payload.
- Availity Essentials – Claim Status application
  - Claim Status application enables Providers and Facilities to digitally submit supporting Claims documentation, including medical records, directly to the Claim.

- Digital Request for Additional Information (Digital RFAI) – the Medical Attachments application on Availity Essentials enables the transmission of digital notifications when additional documentation including medical records are needed to process a Claim.

**Section 5: Electronic remittance advice and electronic Claims payment**

**Electronic remittance advice**

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

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

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

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

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

**Electronic Claims payment**

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

- **Electronic Funds Transfer (EFT)**

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

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

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

- **Virtual Credit Card (VCC)**

  For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit card (VCC). VCC allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

Note that Anthem may receive revenue for issuing a VCC.

**Opting out of virtual credit card payment**. Providers and Facilities are entitled to opt out of electronic payment. To opt out of virtual credit card payment, there are two (2) options:

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

  OR

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

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

  The Zelis Payment Network (ZPN) is an option for Providers and Facilities looking for the additional services Zelis can offer. Electronic payment (ACH or VCC) and Electronic Remittance Advice (ERA) via the Zelis portal are included together with additional services. For more information, go to **Zelis.com**. Zelis may charge fees for their services.

  Note that Anthem may receive revenue for issuing ZPN.

  ERA through Availity is not available for Providers and Facilities using ZPN.

  **To disenroll from ZPN payment,** there are two (2) options:

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

    OR

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

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

# Provider Participation

## Provider Enrollment through Availity

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

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

The system pulls in all your professional and practice details from Council for Affordable Quality Healthcare (CAQH) ProView to populate the information Anthem needs to complete the enrollment

process — including credentialing, claims, and directory administration. The online enrollment application guides the applicant through the process.

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

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

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

## Standards of Participation

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

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

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

## Delivery of Provider Agreements and Amendments

Upon participation in our Commercial, Medicaid, and Medicare networks, the agreed upon location and method of delivery of new Anthem agreements is sent to the email address on file for the Provider.

Upon participation in our Commercial, Medicaid, and Medicare networks, the agreed upon location and method of delivery for Anthem contract amendments is via the Availity Provider Online Reporting tool.

## Provider Effective Date

The credentialing requirements for Anthem Providers follow the credentialing requirements for all lines of business and products offered by Anthem. The effective date will be the latter of the clean credentialing application receipt date or the contract signature date.

Under the law, we are required to establish protocols and procedures for reimbursing new Provider applicants at the contracted in-network rate for approved, covered services provided during the period in which a Provider's credentialing application is pending. The credentialing period begins with the receipt of a completed credentialing application. Incomplete credentialing applications and denied applications are excluded.

Anthem has implemented necessary requirements to comply with Virginia statutory requirements regarding effective dates. If you are a new Provider applicant under credentialing review for participation in Provider networks offered by Anthem, these regulations will allow you to see Anthem members and retroactively receive payments if you are ultimately credentialed.

If you are a Provider who submits a completed credentialing application to us, Anthem will adhere to the requirements specified in the Virginia Code § 38.2-3407.10:1. Providers are also required to adhere to the Virginia Code § 38.2-3407.10:1 regarding Member notification during the credentialing process.

**Hold claims for Anthem members:**

During the credentialing period, Providers are required to hold claims for our members until Anthem sends a final notification of a credentialing decision. If you submit claims to Anthem during the credentialing period before receiving a credentialing decision, claims for the impacted lines of business noted above will be rejected or denied indicating that the claims must be resubmitted upon a final credentialing decision. Members will be protected from inappropriate billing and held harmless during this period.

# Credentialing

## Credentialing Program Description

### Anthem's Discretion

The credentialing summary, criteria, standards and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of Anthem's credentialing program (Credentialing Program) nor is it intended to create rights on the part of

practitioners or HDOs who seek to provide healthcare services to Members. Anthem further retains the right to approve, suspend or terminate individual physicians and health care professionals and sites in those instances where it has delegated credentialing decision-making.

**Definitions**

**AAAHC**: Accreditation Association for Ambulatory Health Care

**QUAD A**: American Association for Accreditation of Ambulatory Surgery Facilities

**AAMFT:** American Association for Marriage and Family Therapy

**AAPSF**: Accreditation Association for Podiatric Surgical Facilities

**ABCOP:** American Board for Certification in Orthotics and Prosthetics

**ABCN**: American Board of Clinical Neuropsychology

**ABMS**: American Board of Medical Specialties

**ABN**: American Board of Professional Neuropsychology

**ACHC**: Accreditation Commission for Health Care

**ACPE:** Association for Clinical Pastoral Education

**Administrative Action**: A decision to terminate or reject a Practitioner, Provider or HDO from network participation for which Anthem's basis for action is based on something other than the competence or professional conduct of a Provider, which affects or could adversely affect the health or welfare of a patient.

**Adverse Administrative Action:** A Company decision to terminate or reject a provider from network participation for other than a Professional Review Action.

**Adverse Credentialing Decision:** A Company decision to deny initial application or terminate a currently credentialed Provider's network participation when information reviewed during initial credentialing, re-credentialing or ongoing monitoring indicates that credentialing, re-credentialing or ongoing monitoring requirements are not met.

**Enterprise**: Refers to Anthem, Inc., and its Affiliates.

**Anthem**: also referred to as the "Company." Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and/or those companies that are under common control with Anthem Health Plans of Virginia, Inc.

**Enterprise Medical Directors**: Those medical directors with responsibility for the Medical Operations and Quality Management activities of the various companies of Anthem.

**AOA**: American Osteopathic Association

**Attestation**: A signed statement indicating that a practitioner or HDO designee personally confirmed the validity, correctness, and completeness of his, her or its credentialing application at the time that he, she or it applied for participation.

**BOC:** Board of Certification/Accreditation

**CABC**: Commission for the Accreditation of Birth Centers

**CARF**: Commission on Accreditation of Rehabilitation Facilities

**Certification review**: verification of criteria required for practice, training, and/or delivery of clinical services, including but not limited to licensure, and/or compliance with regulatory requirements and/or state or federal contract requirements for provision of such services.

**CHAP**: Community Health Accreditation Program

**CIHQ**: Center for Improvement in Healthcare Quality

**Clinical Peer**: A Practitioner, not otherwise involved in Anthem's network management, whose practice is in the same or a similar Specialty.

**COA**: Council on Accreditation

**TCT**: The Compliance Team

**Anthem Credentials Committee (CC)**: A local multi-disciplinary committee that has representation from appropriate types of practitioners and specialties.

**Credentialing staff**: Any associate in the Anthem Credentialing Department.

**DNV NIAHO**: Det Norske Veritas (DNV) Healthcare, Inc. NIAHO National Integrated Hospital Accreditation for Healthcare Organizations Program

**For Cause Termination**: A termination related (1) failure of a Provider to meet predetermined credentialing criteria related to professional conduct and competence; (2) quality of care; (3) patient safety; and (4) professional conduct or competence which affects or could adversely affect the health or welfare of a patient and/or that in the determination of the CC poses some potential risk to the health of the Anthem's Members.

**Formal Appeal**: The process by which Anthem's Adverse Credentialing Decision is challenged.

**Health Delivery Organization (HDO)**: A facility, institution or entity that is licensed or certified (as applicable), in accordance with all applicable state and/or federal laws, that provides or delivers health care services.

**HQAA**: Healthcare Quality Association on Accreditation

**Immediate Termination**: a termination of network participation which is effective immediately. It occurs prior to review by the geographic Credentials Committee, and prior to the Provider being allowed an appeal, if applicable. It is used when determined necessary by Anthem to protect against imminent danger to the health or welfare of Anthem's Members or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs.

Termination due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs do not go to the geographic Credentials Committee for review are not eligible for Informal Review/Reconsideration or Formal Appeal (see Credentialing Policies #13 and 14).

**IMQ**: Institute for Medical Quality

**Informal Review/Reconsideration**: A process through which an initial applicant or participating provider submits additional information to Anthem to correct or augment the information which resulted in an Adverse Administrative Action or Adverse Credentialing Decision. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the Informal Review/Reconsideration, Anthem, at its discretion, may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Anthem representative telephonically. In any event, an Informal Review/Reconsideration shall not include privileges equal to or greater than those offered in a Formal Appeal.

**Initial Applicant**: Any person or organization that provides health care services which has applied for participation with Anthem to provide health care services to Anthem's Members.

**Members**: Refers to Members or Covered Individuals.

**Mental Health Condition**: A condition that may impair the individual's judgment or emotional stability. Any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors.

**National Practitioner Data Bank (NPDB)**: A federal data bank maintained by the U.S. Department of Health & Human Services, or its authorized contractor, which houses information regarding Providers and any state or federal sanctions, closed malpractice cases where findings are for the plaintiff, settlements and hospital privilege actions.

**National Register of Health Service Providers in Psychology (a.k.a. The Register)**: An organization providing primary source verification for education and training and Board Certification of psychologists. This entity has "deemed status" from NCQA.

**NEBO:** The National Examining Board of Ocularists

**Participating Provider**: Any person or organization that provides health care services and which has credentialed by and has entered into an agreement with Anthem to provide health care services to Company's Members.

**Peer Review**: Evaluation or review of the professional competency and conduct of colleagues by professionals with similar types and degrees of expertise (e.g., the evaluation of one physician's practice by another physician)

**Physical Condition or Impairment**: A physical disability or presence of an illness that may interfere with a Practitioner's ability to practice to the fullest extent of their Specialty with or without accommodation or that could pose a risk of harm for patients.

**Practitioner**: An individual person who is licensed or certified (as applicable) in accordance with all applicable state and federal laws to deliver health care services.

**Professional Conduct and Competence Review**: peer review by the geographic Credentialing Committee that assesses a Provider's conduct and qualifications in accordance with Anthem Credentialing Policies.

**Professional Review Action**: A decision to terminate or reject a Provider from network participation that is based on the competence or professional conduct of a Provider which affects or could adversely affect the health or welfare of a patient.

**Provider**: Any licensed or certified (as applicable) person or institution that provides health care services, including practitioners and HDOs.

**Substance Use Disorder-Condition**: A condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on legal or illegal drugs which results in a chronic disorder affecting physical health and/or personal or social functioning.

**TJC**: The Joint Commission

## Policy 1: Credentialing Program Structure

A. The National Credentials Committee (NCC) establishes the policies and procedures for:

1. Credentialing, re-credentialing, ongoing monitoring and oversight of network practitioners and HDOs; and
2. The delegation of credentialing related activities; and
3. Appeals of adverse credentialing decisions; and
4. Review of Anthem's Company's clinical staff qualifications and approval for those staff to perform clinical functions on behalf of Anthem.

B. The NCC policies will:

1. Comply with relevant federal law; and
2. Meet standards set by relevant regulatory and accrediting bodies; and
3. Be modified for state specific use to comply with state law where applicable; and
4. Be reviewed at least annually and revised as necessary.

C. The NCC is:

1. Composed of ten to twelve Company medical directors selected to represent various clinical and business areas of Anthem; representation shall include the following:
    a. At least two medical directors representing Commercial and Medicaid lines of business, respectively, and one medical director representing Medicare line of business; and
    b. At least one medical director representing behavioral health; and
    c. At least two medical directors who act as chairs/vice-chairs of geographic Credentials Committees (as detailed in Credentialing Policy #3); and
2. Chaired by an Anthem medical director as designated by the Vice President (VP) responsible for Enterprise Credentialing Policy. The VP responsible for Enterprise Credentialing Policy reports to Anthem Chief Medical Officer.

D. Anthem shall:

1. Maintain an appropriate staff to implement credentialing policy; and
2. Establish a geographic Credentials Committee (CC) (as detailed in Credentialing Policy #3) to perform credentialing review of practitioners and HDOs and render determinations; and
3. Review and provide input on the policies established by the NCC; and
4. Adopt and implement the policies and procedures set forth by the NCC.

E. Anthem establishes a local credentialing and peer review body known as the geographic Credentials Committee (CC). The CC is authorized by the NCC to evaluate and determine eligibility for practitioners and HDOs to participate in Anthem's credentialed provider network(s) and be listed in Anthem's provider directories. The CC's functions are governed by Enterprise Anthem Credentialing Policy and are supported by Anthem credentials staff (see credentialing Policy #3).

## Policy 2: Credentialing Program Scope

**Credentialing requirements apply:**

- Practitioners who are licensed, certified or registered by the state to practice independently (without direction or supervision).
- Practitioners who have an independent relationship with the organization.
- An independent relationship exists when the organization directs its Members to see a specific practitioner or group of practitioners, including all practitioners whom Member can select as primary care practitioners.
- Practitioners who provide care to Members under the organization's medical benefits.
- The criteria listed above apply to practitioners in the following settings:
- Individual or group practices.
- Facilities.
- Rental networks:
    - That are part of the organization's primary network, and the organization has Members who reside in the rental network area.
    - Specifically, for out-of-area care and Members may see only those practitioners or are given an incentive to see rental network practitioners.
- Telemedicine.

**Professional Practitioners:**

A. Practitioner Types: Anthem credentials the following types of licensed/state-certified independent health care practitioners when the exclusions in section b (see below) do not apply:

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

- Physician assistants;
- Registered Dietitians.

B. Practitioners with whom Anthem has a contractual relationship do not require credentialing when the Practitioner:

- Practices exclusively in an inpatient setting and provides care for Members only because Members are directed to the hospital or another inpatient setting; OR
- Practices exclusively in free-standing facilities and provides care for Members only because Members are directed to the facility.

Examples of this type of practitioner include, but are not limited to:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency Room Physicians
- Urgent Care Center mid-level providers (e.g. nurse practitioners, physician assistants)
- Hospitalists
- Pediatric Intensive Care Specialists
- Other Intensive Care Specialists

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

- Certified Behavioral Analysts;
- Certified Addiction Counselors;
- Substance Use Disorder Practitioners.

**Note:** an individual who is contracted and practices in the office setting must be credentialed when that practitioner meets criteria in section b of this Credentialing Policy, above.

**Healthcare Delivery Organizations (HDOs):**

A. Anthem credentials the following types of HDOs:

- Hospitals;
- Home Health Agencies;
- Skilled Nursing Facilities (Nursing Homes);
- Ambulatory Surgical Centers;
- Behavioral Health Facilities providing mental health and/or substance use disorder treatment in inpatient, residential or ambulatory settings:
    - Adult Family Care/Foster Care Homes;
    - Ambulatory Detox;
    - Community Mental Health Centers (CMHC);
    - Crisis Stabilization Units;
    - Intensive Family Intervention Services;
    - Intensive Outpatient – Mental Health and/or substance use disorder;
    - Methadone Maintenance Clinics;

    - Outpatient Mental Health Clinics;
    - Outpatient substance use disorder Clinics;
    - Partial Hospitalization – Mental Health and/or substance use disorder;
    - Residential Treatment Centers (RTC) – Psychiatric and/or substance use disorder;
  - Birthing Centers;
  - Home Infusion Therapy when not associated with another currently credentialed HDO;
  - Durable Medical Equipment Providers

B. The following Health Delivery Organizations are not subject to professional conduct and competence review under Anthem's Credentialing Program, but are subject to a certification requirement process:

  - Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
  - End Stage Renal Disease (ESRD) service providers (dialysis facilities) (CMS Certification or National Dialysis Accreditation Commission))
  - Hospices (CMS Certification)
  - Portable x-ray Suppliers (CMS Certification)
  - Federally Qualified Health Centers (FQHC); (CMS Certification)
  - Rural Health Clinics; (CMS Certification)
  - Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
  - Orthotics and Prosthetics Suppliers (American Board for Certification in Orthotics and Prosthetics_(ABCOP) or Board of Certification/Accreditation (BOC) or The National Examining Board of Ocularists (NEBO))

## Policy 3: Credentials Committee

A. All credentialing determinations are made by Anthem's Credentials Committee (CC), which reports to Anthem's governing board. The CC is authorized, under authority from the governing body of Anthem and under the direction of the Chief Medical Officer of Anthem, to evaluate all health care Practitioners and Healthcare Delivery Organizations (HDOs) within the scope the Credentialing Program applying for participation or seeking continued participation in the Anthem network.

B. These applicants will be reviewed for issues related to their meeting the Company's established credentialing criteria. The CC may authorize the chair/vice-chair or a designated Anthem Medical Director to approve providers meeting all predetermined criteria for credentialing or re-credentialing. Upon individual review of providers not meeting predetermined criteria, the CC may accept or deny those Practitioners or HDOs initially applying for participation, and to retain or terminate those Practitioners or HDOs requesting continued participation in the Company's programs or provider network(s).

C. The CC is composed of:

  - At least five (but no more than ten) external participating physicians representing multiple medical specialties:
  - In general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair.
  - Exception: representation of a specialty or practice-type is not required if: That specialty or

practice-type is not provided in the geographic region represented by the CC; or

- That specialty or practice-type representation cannot be achieved because of recruitment difficulties AND the chair/vice-chair of the CC deems that ad hoc representation of said specialty or practice-type can be achieved by external consultation as needed to complete the review of credentials of a Practitioner.
- Committee membership may, but does not necessarily also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion (e.g. volume of provider types in the region).
- At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC; AND
- A chair, designated after review and approval by the chair of the National Credentials Committee (NCC), who is a state or regional lead medical director, or an Anthem Associate designee directly thereof; AND
- A vice-chair, designated after review and approval by the chair of the NCC, in states or regions where both Commercial and Medicaid contracts exist, who is the lead medical officer or an Anthem Associate designee directly thereof, for that line of business not represented by the chair.

**Note:** in states or regions where only one line of business is represented, the chair of the CC will designate after review and approval by the chair of the NCC, a vice-chair, who is an Anthem medical director, for that line of business represented by the chair.

**Note:** in states or regions where Medicare Advantage (MA) is represented, a second vice-chair representing MA may be designated after review and approval by the chair of the NCC.

**Note:** In states or regions where an Anthem affiliated provider organization is represented, a second vice-chair representing that organization may be designated after review and approval by the chair of the NCC.

The CC will meet, at minimum, as often as necessary to meet the requirements of accreditation, regulation, or contract, but in any event at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chair/vice-chair will serve as voting member(s) and provide support to the credentialing/recredentialing process as needed. The CC will include at least five, but no more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a Practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic

competition with the Practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the Practitioner. If a current or previous member of the CC requires committee review for any reason, the review will not be performed by the CC on which the practitioner participated. The review will occur at the CC of an Anthem affiliate. Determinations to deny an applicant's participation or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

Practitioners and HDOs who meet all participation criteria for initial or continued participation (including off-cycle review) and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the chair/vice-chair of the CC after review of the applicable credentialing or re-credentialing information. This information may be in summary form and must include, at a minimum, Practitioner's name and specialty.

Practitioners and HDOs who (1) do not meet all of Anthem's participation or credentialing criteria, or (2) have other issues that require individual consideration, are presented to the CC for individual review. If the CC requests additional information, Anthem's credentialing staff will collect follow-up information and add it to the applicable Practitioner's file. The file is then resubmitted to the CC for reconsideration at its next meeting.

The Committee may discuss whether the information submitted as part of the application, or reapplication process appears to support that the providers are meeting reasonable standards of professional competence and conduct.

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

Providers requesting initial participation will be notified of the decision by appropriate Anthem personnel within ninety (90) days of receipt of a completed application or within 60 days of the CC decision, whichever is earlier. This notification may occur electronically or via standard mail.

## Policy 4: Professional Competence and Conduct Criteria – Practitioners

Each health care practitioner applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of Anthem's programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Practitioners within scope of credentialing policy are listed in Credentialing Policy #2.

The NCC determines the practitioner types defined within scope of Anthem's Credentialing Program, as established by, but not limited to perceived risk to Members and volume of services rendered.

**Note:** Additional practitioner types, when explicitly required by specific regulatory or contractual obligations, may be reviewed according to contractual requirements and/or local, state, and federal regulations; however, such review lies outside the scope of this Credentialing Policy #4.0.

**Health Care Practitioners**

**Eligibility Criteria Not Subject to Committee Review** – all health care practitioners within the scope of Anthem's Credentialing Program applying for participation in Anthem's programs or provider network(s) must meet the following criteria in order to be considered for participation. Applicants for initial participation in Anthem's programs or provider network(s) who do not meet the criteria below will be notified of this failure to meet criteria and their applications will not proceed through the credentialing process.

A. Must not be currently sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP). **Note:** If, once a practitioner participates in Anthem's programs or provider network(s), debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the practitioner will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem's other credentialed provider network(s).

B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Anthem's Members; unless an exception to this requirement applies (see below).

C. Possess a current, valid, and unrestricted DEA or CDS registration for prescribing controlled substances, if applicable to their specialty in which he/she will treat Anthem's Members (see list below for practitioner types who do not require a DEA or CDS); unless an exception to this requirement applies. The DEA/CDS must be valid in the state(s) in which the practitioner will be seeing Anthem's Members. Practitioners who see Members in more than one state must have a DEA/CDS for each state.

D. Meet the education, training and certification criteria as required by Anthem.

   Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee – all health care practitioners within the scope of Anthem's Credentialing Program applying for participation in Anthem's programs or provider network(s) must meet the following criteria in order to be considered for participation. If an applicant for initial participation or continued participation in Anthem's programs or provider network(s) does not meet one or more of the following criteria, the applicant's history must not raise a reasonable suspicion of future substandard professional conduct and/or competence. The CC will consider the applicant's history on an individual basis pursuant to Credentialing Policy.

   1. Exception to state license requirements may be made in the following instances:

      a. For initial applicants whose licensure action was related to substance use disorder, physical impairment or mental illness and that have demonstrated a minimum of two years of successful participation in a treatment and/or monitoring program with no evidence of recidivism, recurrence or relapse since the institution of the treatment/monitoring. In the event this exception is considered, Anthem may request specific documentation from the treating physician and/or program as it deems appropriate, as detailed in Credentialing Policy #16. These applicants will be subject to review per Credentialing Policy.

      b. For applicants previously terminated from Anthem's provider network(s) related to

licensure action for substance use disorder per Credentialing Policy #16, that have demonstrated a minimum of one (1) year of successful participation in a treatment and/or monitoring program with no evidence of recidivism since that time. Should this exception be entertained, Anthem may request specific documentation from the treating physician and/or program as it deems appropriate. These applicants will be subject to review per Credentialing Policy.

c. In jurisdictions where the licensing entity issues licenses to new applicants at a frequency less than monthly, but does issue temporary licenses, Anthem may at its discretion, accept a temporary license. In instances where a temporary license is accepted, Anthem will also establish a timeframe in which a permanent license is required. These will be viewed as Level I files and will not require Credentials Committee review. Anthem will view any encumbrances, probations or other restrictive actions taken against such an applicant as not meeting criteria.

d. In jurisdictions where the licensing entity issues a limited license with geographic limitations that are unrelated to professional conduct or competence (e.g. immigration status), Anthem may, at its discretion accept a limited license. These will be viewed as Level I (See Credentialing Policy #8) files and will not require Credentials Committee review. Anthem will view any encumbrances, probations or other restrictive actions taken against such an applicant as not meeting criteria.

2. Indian Health Services (IHS) practitioners who provide services in states which recognize HIS licensure as a proxy for the Practitioner's state licensure do not require a same state license. The IHS license will be verified and documentation showing state acceptance of the IHS license will be recorded. An exception to DEA or CDS registration requirements may be made in the following instances: (**Note:** For practitioner types who do not require a DEA or CDS registration see below. In the event that any of these practitioners do have a DEA or CDS registration, it will be subject to verification).

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

        1. It can be verified that the applicant's application is pending; and Verification that the applicant's DEA/CDS application is pending;

        2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; If the alternative provider is a practice rather than an individual, the file may include the practice name. Anthem is not required to arrange an alternative prescriber;

        3. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration;

        4. Verification of the appropriate DEA/CDS via standard sources; and

        5. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a 90 day timeframe will result in termination from the network.

    b. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's Members will be notified of the need to obtain the

additional DEA. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

1. Verification that the applicant's DEA application is pending;
2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained;
3. The applicant agrees to notify Anthem upon receipt of the required DEA registration;
4. Verification of the appropriate DEA registration via standard sources; and
5. The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.

c. Practitioners, excluding those practitioners and physician specialties listed on below, who voluntarily choose to not have a DEA/CDS registration, if that Practitioner certifies the following:

1. DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than voluntary choice.

2. Controlled substances are not prescribed within their scope of practice, or in their professional judgement, the patients receiving their care do not require controlled substances; and Practitioner provides documentation to Anthem that describes their process for handling instances when a patient requires a controlled substance; OR
3. Prescribing controlled substance is in the scope of practice but the Practitioner provides documentation to Anthem that an arrangement exists for an alternative Provider to prescribe controlled substances if it is clinically appropriate. If the alternate provider is a practice rather than an individual, the file may include the practice name. Anthem is not required to arrange an alternative prescriber.

**Practitioner Types and Physician Specialties Not Requiring DEA and CDS Registration**

1. Allergy and Immunology
2. Chiropractors
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/ Counselors, Nurse Practitioners working in behavioral health)
5. Nurse practitioners
6. Physician's assistants
7. Certified nurse midwives
8. Medical Genetics
9. Medical Therapists, e.g. physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
10. For continued participation of assistant surgeons upon re-credentialing, if that physician certifies that he/ she: (1) will deliver services to Anthem's Members in an assistant surgeon capacity only; and (2) has let his or her DEA registration voluntarily lapse because controlled substances requiring a DEA registration are not prescribed within the limited scope of that assistant surgeon's

practice. However, re-credentialing is not allowed if the assistant surgeon's DEA registration is or was suspended, revoked, or surrendered for other reasons.

11. Radiologists practicing in an office setting
12. Pathologists practicing in an office setting
13. Licensed Genetic Counselors
14. Audiologists
15. Acupuncturists (non-MD/DO)
16. Registered Dietitians

Application and supporting documentation must not contain any omissions or falsifications, (including any additional information requested by Anthem), or in the presence of omission or falsifications must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Education, training and certification must meet criteria for the specialty in which the applicant will treat Anthem's Members including receipt of documentation of such education, training and certification from institutions acceptable to Anthem, or in the absence of such must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

For MD's and DO's, current, in force board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical discipline for which they are applying is viewed as meeting all education, training and certification requirements. As alternatives, MD's and DO's meeting any one of the following criteria will be viewed as meeting this education, training and certification requirement:

1. Previous board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical Specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice. OR
2. Training which met the requirements in place at the time it was completed in the Specialty or subspecialty field prior to the availability of Board Certifications in that clinical Specialty or subspecialty. OR
3. Specialized practice expertise as evidenced by publication in nationally accepted Peer Review literature and/or recognized as a leader in the science of their Specialty AND a Faculty Appointment of Assistant Professor or higher at an Academic Medical Center and Teaching Professional in Anthem's Network AND the applicant's professional activities are spent at that institution at least 50% of the time.

   **Note:** providers meeting one of the alternative criteria specified above will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the geographic Credentials Committee.

4. The individual is seeking provider specialty designation listing as a General Practitioner and meets the criteria outlined in (1) and (2):
   a. Meets both of the following criteria:
      i. One year of training in the United States in a clinical discipline involving direct patient care in primary care, OB/Gyn or general surgery or any combination of these; AND
      ii. A minimum of 10 years of clinical practice experience; AND
   b. Meets one of the following criteria for network inclusion of a General Practitioner:
      i. Demonstrates significant access need or extenuating or special circumstances that

warrant consideration, i.e. applicant has unique skills not otherwise available in network, e.g. procedural, special language skills; or there is a need for this specialty in this geographic area for access reasons: rural location and/or underserved population not served by other practitioners; AND

ii. Meets all credentialing criteria and processes outlined in Credentialing Policies.

Anthem reserves the right, in its reasonable discretion, to waive the board Certification or alternative requirement when Anthem determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

Individuals will be granted five years – or in the case ABMS board certification, a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement unless the extenuating or special circumstances described in the above statement apply.

This board Certification requirement will not apply to MD's and DO's credentialed by the Anthem (or by an authorized delegated entity consistent with Anthem's credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by Anthem of the need to become board certified. All practitioners will continue to undergo oversight through the standard re-credentialing and ongoing monitoring mechanism. Additionally, Anthem's CC will assess unique situations where issues of limited access to care may dictate special consideration.

For DPM's (podiatrists) the applicant must be certified by either the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery. As an alternative, podiatrists who were previously board certified by either the American Board of Podiatric Medicine or the American Board of Foot and Ankle Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this requirement. Podiatrists who meet the alternative requirement will not require additional review. Anthem reserves the right, in its reasonable discretion, to waive the board Certification requirement when Anthem determines: 1) That there are extenuating or special circumstances that warrant the waiver of such requirement AND 2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement. However, individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

This board Certification requirement will not apply to podiatrists credentialed by Anthem (or by an authorized delegated entity consistent with Anthem's credentialing policy) and in good standing in the network as of the effective date of this policy, unless they had been previously notified by Anthem of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing and ongoing monitoring mechanism. Additionally, the Anthem CC will assess unique situations where issues of limited access to care may dictate special consideration.

For Oral and Maxillofacial Surgeons, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery. As an alternative, Oral and Maxillofacial Surgeons who were previously board certified by the American Board of Oral and Maxillofacial Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this

requirement. Oral and Maxillofacial Surgeons who meet the alternative requirement will not require additional review.

Anthem reserves the right, in its reasonable discretion, to waive the board Certification requirement when Anthem determines that there are extenuating or special circumstances that warrant the waiver of such requirement.

Individuals will be granted five years after completion of their residency or fellowship training program to meet the board Certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement.

This board Certification requirement will not apply to Oral and Maxillofacial Surgeons credentialed by Anthem (or by an authorized delegated entity consistent with Anthem's credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by Anthem of the need to become board certified. All practitioners will continue to undergo oversight through the standard recredentialing and ongoing monitoring mechanism. Additionally, the Anthem CC will access unique situations where issues of limited access to care may dictate special consideration.

For MD's and DO's, the applicant must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Some clinical disciplines may function exclusively in the outpatient setting, and Anthem's CC may at its discretion deem hospital privileges not relevant to these specialties. (See Attachment B.) Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. Anthem CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians is that there exists an appropriate referral arrangement with a network physician providing inpatient care.

For Genetic Counselors, the applicant must be licensed by the state to practice independently. If the state where the applicant practices does not license Genetic Counselors, the applicant must be certified by the American Board of Genetic Counseling or the American Board of Genetics and Genomics.

Site visit and medical record review results, if applicable, must meet Anthem standards, or in the absence of meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Complaints from Members and/or other Providers must be at levels deemed acceptable to Anthem, or if such complaints exist and/or exceed such levels must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

Explanations for gaps in work history must be documented and meet Anthem standards, or in the presence of gaps that exceed such standards must not raise a reasonable suspicion of future substandard Professional Conduct and/or Competence.

History of professional liability suits, arbitrations or settlements must be within established Anthem standards, or in the presence of suits exceeding such standards, these suits, arbitrations or settlements must not raise a reasonable suspicion of future substandard Professional Conduct and/or Competence.

Performance indicators obtained during the credentialing, recredentialing or ongoing monitoring process that meet Anthem standards, or if not meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

No physical or mental impairment, (including chemical dependency and substance use disorder), that would affect the health care Practitioner's ability to practice within the scope of his or her license or pose a risk or imminent harm to Members. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing or ongoing monitoring process must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

No history of disciplinary actions or sanctions against the applicant's license, DEA and/or CDS registration or any actions or sanctions of such nature as to raise a reasonable suspicion of future substandard Professional Conduct and/or Competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing and ongoing monitoring process. For applicants with current actions or sanctions, see above.

No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, nothing in the nature of those to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing or ongoing monitoring process.

No convictions, or pleadings of guilty or no contest to, or open indictments of, a felony or any offense involving moral turpitude or fraud. In addition, no other criminal or civil litigation history that together with any other relevant facts, raises a reasonable suspicion of future substandard professional conduct and/or competence.

No other significant information, such as information related to boundary issues or sexual impropriety or illegal drug use which might indicate a reasonable suspicion of future substandard professional conduct and/or competence.

## Policy 4.0.1: Behavioral Health Practitioner (non-physicians) – Education Criteria

Anthem has identified and developed minimum acceptable criteria for all practitioners who fall within the scope of its credentialing program. This policy specifically addresses only the education and training requirements of non- physician behavioral health practitioners. All relevant requirements detailed in this Credentialing Policy #4.0 including but not limited to: licensure, DEA (where applicable) work history (gaps and performance), disciplinary actions of any licensure agency, regulatory body, employer or managed care Anthem, criminal actions, impairments and/or substance use disorder, site visits, liability experience, disclosure of adverse actions and Attestation during the application are applicable to these practitioners as well.

These criteria outlined in this policy do not apply to those Providers credentialed by the Anthem (or an authorized delegated entity consistent with Anthem's credentialing policy) and in good standing as of the effective date of this policy. These practitioners will continue to undergo oversight through standard re-credentialing mechanisms.

Practitioners are reviewed for both initial credentialing, re-credentialing and ongoing monitoring in accordance with the following minimum standards for participation. These Credentialing criteria

pertain to all practitioners of these Provider types. Practitioners will be credentialed according to the criteria applicable to their highest level of licensure. Practitioners failing to meet minimum criteria would be viewed as not eligible for participation. Anthem Credentials Committee (CC) may, however, assess unique access needs where issues of limited access to care may dictate special consideration. In these instances, the absence of any certification or other requirement must not raise a reasonable suspicion of future substandard conduct and competence.

A. Provider Type Eligibility Criteria – Education and Training (by provider type)

1. (LCSW) LICENSED CLINICAL SOCIAL WORKERS or other masters level social work license type based on state licensing regulations.

   Practitioner shall possess a master's or doctoral degree in social work. If a masters level degree does not meet criteria and the Provider obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. In addition, a Doctor of Social Work will be viewed as acceptable.

2. LICENSED PROFESSIONAL COUNSELOR (LPC), MARRIAGE & FAMILY THERAPIST (MFT), Licensed Mental Health Counselor (LMHC) or other master level license type based on state licensing regulations. Practitioner shall possess a masters or doctoral degree in one of the following fields: counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental health field. Master or Doctoral degrees in Education are acceptable with one of the fields of study above. Master or Doctoral Degrees in Divinity, Masters in Biblical Counseling, or other primarily theological field of study, do not meet criteria as a related field of study.

   Practitioners with PhD training as a clinical psychologist can be reviewed. Practitioners with a Doctoral degree in one of the fields of study noted will be viewed as acceptable.

   Licensure to practice independently or in states without licensure or certification:

   **1.** Mental Health Counselors with a master's degree or higher: provider applicant must be a Certified Clinical Mental Health Counselor (CCMHC) as determined by the Clinical Academy of the National Board of Certified Counselors (NBCC) [proof of NBCC certification required] or meet all requirements to become a CCMHC [documentation of eligibility from NBCC required].

   2. Marriage & Family Therapists with a master's degree or higher: Certified Confirmed eligibility or certification as a full clinical member of the American Association for Marriage and Family Therapy (AAMFT), (documentation from AAMFT required).

   3. Pastoral Counselors:

      a. Practitioner shall possess a master's or doctoral degree in a mental health discipline:

      b. Either licensed as another recognized behavioral health provider type (e.g. MD/DO, PsyD, SW, RNCS, ARNP, and MFT, OR LPC) at the highest level of independent practice in the state where the practice is to occur, or licensed or certified as a pastoral counselor in the state where the practice is to occur; and

      c. Be a fellow or diplomat member of the Association for Clinical Pastoral Education (ACPE) or meet all requirements to become a fellow or diplomat member of the ACPE [documentation of eligibility of ACPE required].

   4. Clinical Nurse Specialist/Psychiatric & Mental Health Nurse Practitioner

Practitioner shall possess a master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing.

Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State Board of Registered Nursing, if applicable.

Certification by the American Nurses Credentialing Center (ANCC), a subsidiary of the American Nurses Association (ANA) in psychiatric nursing or the Pediatric Nursing Certification Board. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable with appropriate supervision/consultation by a participating psychiatrists as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate State Controlled Substances Certificate if required.

5. Clinical Psychologists

   A valid state clinical psychologist license and, a Doctoral degree (PhD, PsyD, EdD) in clinical or counseling psychology or other applicable field of study.

   Master level therapists in good standing on the network, who upgrade their license to clinical psychologist as a result of further training will be allowed to continue in the network and will not be subject to the above education criteria.

6. Clinical Neuropsychologist

   Standard Criteria – Candidates must meet all the criteria for a clinical psychologist listed in section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABN) or American Board of Clinical Neuropsychology (ABCN) or in the absence of such certification does not raise a reasonable suspicion of future substandard conduct or competence.

   Alternative Criteria – Alternatively, a Provider credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered, subject to review by the CC.

   Other Criteria – Clinical neuropsychologists who are neither board certified nor listed in the National Register will require individual CC review. These Providers must have appropriate training and/or experience in neuropsychology as evidence by one or more of the following:

   a. Training:
      i. Transcript of applicable pre-doctoral training; or
      ii. Documentation of applicable formal 1-year post-doctoral training. (Participation in CEU training alone would not be considered adequate); or
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week.
   b. Experience:
      i. Minimum of 5 years' experience practicing neuropsychology at least 10 hours per week.

7. Licensed psychoanalysts

   Applies only to practitioners in states that license psychoanalysts.

Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).

Practitioner must possess a valid psychoanalysis state license.

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

## Policy 4.0.2: Credentialing of Nurse Practitioners, Certified Nurse Midwives and Physician's Assistants

The purpose of this policy is to address the credentialing of NPs, CNMs and PAs when an independent relationship exists between Anthem and the Practitioner, and such individual practitioner is listed individually in the network directory. Credentialing is not required if the NP, CNM, or PA provides care for Members only because Members are directed to a facility or contracted physician that employs the Practitioner.

**General Criteria and Process:**

Anthem has identified and developed minimum acceptable criteria for all practitioners who fall within the scope of its credentialing program. This Credentialing policy specifically addresses only the education and training requirements of Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs). All relevant requirements detailed in Credentialing Policy #4.0 including but not limited to: licensure, DEA (where applicable) work history (gaps and performance), disciplinary actions of any licensure agency, regulatory body, employer or managed care company, criminal actions, impairments and/or substance use disorder, site visits, liability experience, disclosure of adverse actions and attestation during the application are applicable to these practitioners as well. Also, all requirements for primary source verification outlined in Credentialing Policy are to be enforced. These include license, DEA (if applicable), education (if not performed by the state licensing body) and procurement of an NPDB report.

**Ongoing Monitoring:**

Midlevel practitioners added to the network will be subjected to the ongoing monitoring processes outlined in Credentialing Policy #12 and will be re-credentialed every three years as described in Credentialing Policy #9. The credentialing and re-credentialing process will occur as described in Credentialing Policies #4, through #9.

**Completed Credentialing:**

On successful completion of credentialing, the NPs/CNMs/PAs name will appear in a directory. The directory listing must clearly delineate the licensure type of the midlevel Practitioner.

**Process, Requirements and Verification - Nurse Practitioners**

A. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

B. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing

agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with Credentialing Policy.

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

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

E. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:

1. Certification program of the American Nurse Credentialing Center, a subsidiary of the American Nursing Association, or
2. American Academy of Nurse Practitioners Certification Program, or
3. National Certification Corporation, or
4. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (**Note:** CPN – certified pediatric nurse is not a nurse practitioner) or
5. Oncology Nursing Certification Corporation (ONCC) -Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY
6. American Association of Critical Care Nurses ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care

   This certification must be active and primary source verified.

   If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee pursuant to the board certification or alternative requirements set forth for MD's and DO's in Credentialing Policy #4.0.

F. If the NP has hospital privileges, they must have hospital privileges at a CIHQ,TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

G. The NP applicant will undergo the standard credentialing processes outlined in Credentialing Policies. NPs are subject to all the requirements outlined in these policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

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

I. NPs will be clearly identified as such:

   a. On the credentialing file,

   b. At presentation to the Credentialing Committee, and

   c. On notification to Network Services and to the provider database.

**Process, Requirements and Verifications – Certified Nurse Midwives**

A. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other practitioner with the exception of differing information regarding education, training and board certification.

B. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with Credentialing Policy

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

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

E. All CNM applicants will be certified by either:

   1. The National Certification Corporation for Ob/Gyn and Neonatal Nursing, or

   2. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.

   This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee.

F. If the CNM applicant has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse

action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

G. The CNM applicant will undergo the standard credentialing process outlined in Credentialing Policies.
CNMs are subject to all the requirements of these policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

H. Upon completion of the credentialing process, the CNM may be listed in Anthem directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy.

I. CNMs will be clearly identified as such:

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

**Process, Requirements and Verifications – Physician's Assistants (PA)**

The PA applicant will submit the appropriate application and supporting documents as required of any other practitioners with the exception of differing information regarding education/training and board certification.

A. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with Credentialing Policy.

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

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

D. All PA applicants will be certified by the National Commission on Certification of Physician's Assistants.
This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to Credentialing Policy and submitted for individual review by the Credentialing Committee.

E. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or ACHC accredited hospital, or a network hospital previously approved by the committee.

Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

F. The PA applicant will undergo the standard credentialing process outlined in Credentialing Policies. PAs are subject to all the requirements described in these policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

G. Upon completion of the credentialing process, the PA may be listed in Anthem directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process discussed in Credentialing Policy.

H. PA's will be clearly identified such:

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

## Policy 4.1: Professional Competence and Conduct Criteria – Health Delivery Organizations

A. Health Delivery Organizations (HDO's) that participate in Anthem's provider network(s) and are within the scope of the credentialing program must meet appropriate standards of professional conduct and competence as reviewed and determined by Anthem's National Credentials Committee (NCC). HDOs within scope of credentialing policy are listed in Credentialing Policy #2.

B. Each HDO applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of Anthem's programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Required elements and other eligibility criteria for HDO's are described in detail in "Procedures" (below).

C. The NCC determines the HDO types defined within scope of Anthem's program, as established by, but not limited to perceived risk to membership and volume of services rendered.

   1. **Eligibility Criteria Not Subject to Committee Review** – all HDOs within the scope of Anthem Credentialing program applying for initial or continued participation in Anthem's programs or provider network(s) must meet the following criteria in order to be considered for participation:

      a. Possess a current, valid, unencumbered, unrestricted, and non-probationary professional license in the state(s) where it provides services to Anthem's Members, if such license is applicable. **Note:** If, once an HDO participates in Anthem's programs or provider network(s), a HDO's license become non-current, invalid, encumbered, restricted, or probationary, at the time of identification, information will be brought to Anthem's peer review committee for consideration regarding the HDO's continued participation in Anthem's credentialed network. Note: In jurisdictions where the licensing entity issues temporary, conditional, or provisional licenses (provisional license) to new HDO applicants or to HDO applicants fully licensed but adding new services, the Company may, at its discretion accept the provisional license when

issued in accordance with all applicable state requirements. In instances where a provisional license is accepted, the Company will also establish a timeframe in which a permanent license is required. In the event a provisional license is issued due to an encumbrance, probation, or other restrictive action against the licensee, the provisional license will be viewed as not meeting criteria.

b. Must not be currently sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHB). **Note:** If, once an HDO participates in Anthem's programs or provider network(s), exclusion from Medicare, Medicaid or FEHB occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem's other credentialed provider network(s).

c. Must be in good standing with any other applicable state or federal regulatory body as defined in Credentialing Policy.

d. **Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee** – all HDOs within the scope of Anthem's Credentialing Program applying for initial or continued participation in Anthem's programs or provider network(s) should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the geographic Credentials Committee (CC):

   **Note:** If an applicant for initial participation or continued participation in Anthem's programs or networks does not meet one or more of the following criteria, its history must not raise a reasonable suspicion of future substandard professional performance. The CC will consider the applicant's history on an individual basis pursuant to Credentialing Policies #8, and 9. This will be regarded as a Level II review if performed during credentialing or re-credentialing, or an Off Cycle, Level III review if information is received and reviewed between the normal re-credentialing cycle (see Credentialing Policy #12).

   i. Application and supporting documentation must not contain any material omissions or falsifications, including any additional information requested by Anthem.

   ii. Complaints received from Members and/or other providers may be reviewed for compliance with Anthem standards.

   iii. Performance indicators obtained during the credentialing, re-credentialing or ongoing monitoring process, if applicable, must meet Anthem standards.

   iv. No indictments or convictions, or pleadings of guilty or no contest to, a felony or any offense involving fraud, criminal activities, abuse or neglect nor evidence of such conviction or pleadings by the principals of the facility.

   v. Any history of disciplinary actions or investigations, including termination, warnings, or notices of potential poor performance related to the HDO's license or accreditation must be reviewed and must not raise reasonable suspicion of future substandard performance or harm to Members. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, re-credentialing or sanction monitoring process. For HDOs with current actions or sanctions, see Section 1.b above.

vi. Acceptable accreditation from a recognized entity exists or in the absence of this accreditation meets the following criteria:

a. Must have an access needs waiver submitted on their behalf and meet the following criteria:

i. Be confirmed to be delivering services in a designated rural area (based on US Census Bureau); or

ii. Submit a copy of the Medicare or state agency survey report performed within the past 36 months to be retained in the provider's file; and

1. Have no deficiencies noted on Medicare or state oversight review which would adversely affect quality of care or patient safety (see Attachment B for SNFs: scope and severity of identified deficiencies cannot be rated "E, F, G, H, I, J, K or L."); and

2. Have the Medicare or state agency survey approved after individual review to validate compliance with Anthem standards by the Credentials Committee; or

iii. Undergo or have undergone within the prior 36 months a site visit survey and receive a passing score by a designated independent external entity (DIEE) using that external entity's previously established and NCC approved criteria.

iv. If a provider has satellite facilities that follow the same policies and procedures as the provider, the organization may limit site visits to a main facility.

e. Initial HDO Credentialing Process and Standards

i. New HDO applicants submit a standardized application to Anthem for review.

ii. Applicants who meet Anthem initial eligibility criteria will undergo professional conduct and competence review.

iii. As part of eligibility criteria accreditation appropriate for HDO type should be verified per below.

iv. Accredited HDO's or Medicare certified SNFs meeting all criteria will be viewed as Level I providers and may be approved by the chair/vice-chair of the CC or medical director designee (See Credentialing Policies #3, #8).

**HDO Type and Anthem Approved Accrediting Agent(s)**

**Medical Facilities**

| Facility Type (Medical Care) | Acceptable Accrediting Agencies |
|---|---|
| Acute Care Hospital | CIQH, CTEAM, ACHC, DNV/NIAHO, TJC |
| Ambulatory Surgical Centers | TJC, ACHC, AAPSF, AAAHC, QUAD A, IMQ |
| Birthing Center | AAAHC, CABC, TJC |
| Home Health Care Agencies (HHA) | ACHC, CTEAM , DNV/NIAHO, TJC, CHAP |
| Home Infusion Therapy (HIT) | ACHC, CTEAM, HQAA, TJC, CHAP |

| Facility Type (Medical Care) | Acceptable Accrediting Agencies |
|---|---|
| Skilled Nursing Facilities/Nursing Homes | TJC, CARF |
| Durable Medical Equipment Providers | TJT, CHAP, TCT, ACHC, BOC, HQAA |

### Behavioral Health

| Facility Type (Behavioral Health Care) | Acceptable Accrediting Agencies |
|---|---|
| Acute Care Hospital–Psychiatric Disorders | DNV/NIAHO, TJC, ACHC, CTEAM |
| Adult Family Care Homes (AFCH) | ACHC, TJC |
| Adult Foster Care | ACHC, TJC |
| Community Mental Health Centers (CMHC) | AAAHC, CARF, CHAP, COA, ACHC, TJC |
| Crisis Stabilization Unit | TJC |
| Intensive Family Intervention Services | CARF |
| Intensive Outpatient – Mental Health and/or Substance Use Disorder | ACHC, DNV/NIAHO, TJC, COA, CARF |
| Outpatient Mental Health Clinic and/or Licensed Behavioral Health Clinic | ACHC, TJC, CARF, COA, CHAP |
| Partial Hospitalization/Day Treatment – Psychiatric Disorders and/or Substance Use Disorder | DNV/NIAHO, TJC, CARF |
| Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Use Disorder | DNV/NIAHO, TJC, ACHC, CARF, COA |

### Rehabilitation

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

## Policy 5: Initial Application

A. Health Care Practitioners

Each practitioner applying for initial participation in Anthem programs or networks must complete and submit Anthem's applicable credentialing application along with all required supporting documentation. The application process may occur either electronically or on paper.

1. Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the practitioner is physically impaired. The organization must document

the disability in the Practitioner's file if the practitioner uses a signature stamp. Pencils are not an acceptable writing instrument for credentialing documentation. Written documentation must be non-erasable ink.

2. The application materials sent by Anthem include, at a minimum the following:
   a. Cover letter or other explanatory information;
   b. Credentialing application; and
   c. Attestation form
3. A practitioner will be notified that he or she has the right to review information submitted to support their credentialing application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other peer review protected information.
4. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the practitioner within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner of their right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for the submission of this additional information and to whom the information should be sent. Depending upon the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation shall be sent thereafter. All communication on the issue(s) in question, including either copies of the correspondence or a detailed record of phone calls, will be clearly documented in the Practitioner's credentials file. The provider will be given no less than 14 calendar days in which to provide additional information.
5. Responses received from practitioners to requests for clarification will be documented in the credentials file. Oversight of this process for additional information or clarification will be the responsibility of the manager of the credentialing unit.
6. Anthem may request and shall accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The Credentials Committee will review this information and the rationale presented by the applicant to determine if either a material omission has occurred or if other credentialing criteria are met.
7. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Anthem. These include: the provider web site or the provider manual. This notification includes the information needed to make this request. When such requests are received, providers will be notified whether the application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.
8. In completing the application, each applicant must disclose the existence of, and provide explanations for, the following:
   a. Instances in which the applicant has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;
   b. Malpractice history, including pending malpractice suits and payments made by any

malpractice carrier on the Practitioner's behalf for any professional liability claim, suit, or judgment;

c. Involuntary termination by an employer or health care organization or resignation with knowledge of a pending investigation, or is aware that an investigation is pending that may lead to disciplinary action;

d. Revocation, suspension or limitation of privileges at a participating hospital, or resignation with knowledge of a pending investigation or any action which might lead to revocation, suspension or limitation of privileges;

e. Current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;

f. Convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving or fraud, or any offense related to practice of healing arts, or is aware that an investigation is pending that may lead to such action;

g. Instances in which the practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware that an investigation is pending that may lead to such action;

h. Revocations, suspensions or surrenders of the Practitioner's Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, or is aware that an investigation is pending that may lead to disciplinary action if applicable;

i. Physical or mental health reasons which would limit the Practitioner's ability to provide services to a patient;

j. Additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application.

9. All practitioners must sign and date an attestation statement that includes, but is not limited to:

   a. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

   b. Lack of present illegal drug use;

   c. History of licensing board action or felony convictions;

   d. History of loss or limitation of privileges or disciplinary activity;

   e. Current malpractice insurance coverage;

   f. The correctness and completeness of the application;

   g. Permission to release information as needed to complete the credentialing process.

10. Each practitioner must submit, along with the application, at a minimum the following:

    a. Curriculum vitae, resume or work history if work history is not included on the application.

    b. The file will go through a thorough review before it is presented to the Credentials Committee to assess completeness in data. All of the required information must be current when presented to the geographic Credentials Committee (CC) and must be verified within the 180 day period prior to the CC making its credentialing recommendations or as otherwise required by applicable accreditation standards.

B. Health Delivery Organizations (HDO):

1. Each HDO applying for initial participation in Anthem's programs or provider network(s) must complete and submit Anthem's applicable credentialing application along with all required supporting documentation.
2. The application materials sent by Anthem include, at a minimum the following:
    a. Cover letter or other explanatory information;
    b. Credentialing application;
    c. Attestation form.
3. In completing the application, each HDO must disclose the existence of, and provide explanations for, the following:
    a. Instances in which the HDO has been the subject of any disciplinary review or action by any state licensing board or any federal agencies or is aware of a pending investigation that may lead to such action;
    b. Instances in which the HDO's malpractice insurance has been terminated, denied, suspended or limited or is aware of a pending investigation that may lead to such action;
    c. Convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts during the past five (5) years of an HDO principal officer or is aware of a pending investigation that may lead to such action;
    d. Instances in which the facility has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware of a pending investigation that may lead to such action;
    e. Additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application or additional issues regarding issues of professional competence and conduct.
4. All HDO applications must include a signed and dated attestation statement that includes, but is not limited to:
    a. History of loss of license and felony convictions;
    b. Current malpractice insurance coverage; and
    c. The correctness and completeness of the application.
5. Each HDO must submit, along with the application, at a minimum the following:
    a. Medicare certification, if applicable;
    b. Recognized accrediting organization certification or Medicare or state site survey results.
6. Upon request, HDO's will be provided with the status of its credentialing application.
7. Anthem may request and shall accept additional information from the HDO to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale presented by the applicant to determine if either a material omission has occurred or if other credentialing criteria are met.
8. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the HDO to assist in

obtaining the information or to provide detailed information regarding the issue in question. All documentation on the issue(s) in question, including a record of phone calls, will be included in the HDO's credentials file.

9. The file will go through a review before it is presented to the Credentials Committee to ensure completeness in data. All of the required information must be current when presented to the CC and must be verified within the 180 day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

**Non-discrimination Policy:**

Anthem will not discriminate against any applicant for participation in its programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in the selection of practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. Should discriminatory practices be identified through annual review or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

In further effort to prevent and take proactive steps to protect against discrimination in the credentialing process, adherence to Anthem nondiscrimination policy is reinforced at Credentials Committee meetings via inclusion of the following statement on each agenda:

As a Committee member, I will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or health care providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to the members to meet their needs and preferences, this information is not required in the credentialing or recredentialing process. Credentials committee members' decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

**Review and Determination:**

All applications for initial participation in Anthem's programs or provider network(s) shall be reviewed and a determination made by the Credentials Committee.

## Policy 6 (Skipped Intentionally)

## Policy 7: Site Visits

A. Anthem will establish specific criteria and threshold standards related to sites where network

practitioners provide medical care for Anthem's Members. These standards will address at a minimum the following:

1. Physical Accessibility for individuals with special needs
2. Physical Appearance
3. Adequacy and appearance of waiting room space
4. Adequacy of examination room space
5. Availability of appointments
6. Adequacy of medical/treatment record keeping

B. Upon receipt of a Member complaint related to any of the items listed 1-4 above, Anthem will assess the complaint(s) using the established criteria. When the threshold is exceeded, an associate or agent of Anthem will perform a site visit within 60 days from the date the Member complaint was received.

**Procedures**

A. Site Visit Evaluations
   1. Site Evaluation Meeting Standards will be documented as such and practitioner notified. No further actions are required.
   2. Site Evaluations NOT Meeting Threshold Criteria
      a. When a site visit fails to meet standards, the practitioner office will be notified of the details of the deficiencies and a specific, mutually agreeable, time frame for remediation will be established.
      b. Corrective action may consist of:
      c. Submission of a formal written corrective action plan, or
      d. For isolated and easily corrected deficiencies, documentation of correction may be provided as evidence of remediation.
   3. Correction of any deficiencies noted on a site visit will be completed according to a mutually agreed upon timeframe.
   4. All site evaluations not meeting threshold will be reviewed at least every six months for progress towards goal.
   5. The follow up visit will specifically address the deficiencies noted on the earlier review.
   6. When the corrective actions are complete and the deficiencies corrected, a follow-up visit will be performed to document that the deficiencies have been corrected. No further action is required.
   7. When a practitioner fails to correct deficiencies, the issue will be referred to the appropriate quality review committee for additional review and action. If the quality review committee notes a site visit issue that it believes is of sufficient concern for consideration for termination of the Practitioner(s), it will be referred to the Credentialing Committee.
   8. Member complaints regarding site visit issues related to office accessibility and appearance, or waiting room or exam room issues will be summarized every six months. This summary will be reviewed by appropriate quality review committee.

B. Recurrent Complaints About the Same Criteria or Office Site
   1. If the complaint threshold is met again for the same or different office site criteria, another office site visit is required. The same procedure listed under section "I. Site Visit Evaluation" would be followed.

## Policy 8 (Skipped Intentionally)

## Policy 9: Recredentialing

All applicable practitioners and HDOs in Anthem's network are required to be recredentialed at least every (3) three years, unless otherwise required by contract or state regulations.

**Health Care Practitioners:**

If appropriate credentialing data to complete the recredentialing process is not available from the Council for Affordable Quality Healthcare (CAQH) ProView system, a recredentialing packet or an electronic notification will be sent to the practitioner at predetermined time prior to the recredentialing date. When the necessary information is available from the Council for Affordable Quality Healthcare (CAQH) ProView system will be utilized. If after appropriate efforts to facilitate response (including at least one certified letter at some point prior to action by Anthem) the practitioner does not respond in a timely manner the practitioner may be administratively terminated.

Each practitioner applying for continued participation in Anthem's programs or networks must complete and submit Anthem's applicable recredentialing application along with all required supporting documentation.

The application materials include, at a minimum, the following:

a. Explanatory Information
b. Application
c. Attestation form

The practitioner will be notified of their right to review information submitted in support of the application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other Peer Review protected information. In the event that recredentialing information obtained through other sources varies substantially from that provided by the Practitioner, Anthem credentialing personnel will notify the practitioner of this discrepancy and of their right to correct errors or provide further information regarding the apparent discrepancy. This notification may occur in writing or verbally, as circumstances warrant, but will occur within 30 calendar days of the identification of the discrepancy. At the time of this communication the practitioner will also be notified of the specific mechanism by which to correct errors or to provide detailed information as well as to who this information is to be submitted. Complete documentation of this notification including either copies of the correspondence or detailed information regarding phone calls will be maintained in the credentialing file. The practitioner will be allowed no less than 14 calendar days to provide the requested information. All additional information received will be documented in the credentials file.

Upon request, practitioners will be provided with the status of his or her recredentialing application. Written notification of this right is provided via the same mechanism described in the Credentialing Policy. This notification includes the information needed to make this request. When such requests are received, Providers will be notified whether the application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the Provider requests a written response.

Anthem may request and shall accept additional information from the practitioner to correct incomplete, inaccurate, or conflicting credentialing information. The credentials committee will review

this information and the rationale presented and determines if either a material omission has occurred or if other recredentialing criteria are met.

In completing the application, each practitioner must disclose the existence of, and provide explanations for any activity since their last credentialing:

instances in which the practitioner has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;

A. malpractice history, including pending malpractice suits;

B. instances in which the Practitioner's malpractice insurance has been terminated, denied, suspended or limited or is aware that such action is pending;

C. payments made by any malpractice carrier on the Practitioner's behalf for any professional liability claim, suit or judgment(s);

D. involuntary termination by an employer or health care organization, or is aware of a pending investigation that may lead to such action;

E. revocation, suspension or limitation of privileges at a participating hospital, or is aware of a pending investigation that may lead to such action;

F. current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;

G. convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts, or is aware of a pending investigation that may lead to such action;

H. instances in which the practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHBP programs, or is aware of a pending investigation that may lead to such action;

I. revocations, suspensions (or revocations) of the Practitioner's Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, if applicable, or is aware of a pending investigation that may lead to such action;

J. physical or mental health reasons which would limit the Practitioner's ability to provide services to a patient; and

K. additional information such as information regarding boundary issues or sexual misconduct or illegal drug use requested by Anthem to explain or provide details regarding responses obtained on the credentialing application.

All practitioners must sign and date an Attestation statement. This Attestation may occur electronically or on paper and contains information that includes, but is not limited to:

1. Reasons for any inability to perform the essential functions of the position, with or without accommodation
2. Lack of present illegal drug use
3. History of licensing board action or felony convictions
4. History of loss or limitation of privileges or disciplinary activity
5. Current malpractice insurance coverage
6. Attestation to the correctness and completeness of the application
7. Consent to obtain information necessary for recredentialing

Each practitioner must submit, along with the application, at a minimum the following:

Board Certification status information (if applicable)

At the minimum the following information will be verified:

1. A valid state license to practice, and information regarding any sanctions, probations or other actions taken against any state license
2. Copy of a valid DEA and CDS certificate or verification through the National Technical Services Database (if applicable)
3. Board Certification (only if the Practitioner's board Certification has expired or is new since the last credentialing. Not applicable for chiropractors.)
4. History of professional liability history
5. National Practitioner Data Bank Information
6. Hospital privileges or Attestation to participating hospitals (if applicable)
7. Office of the Inspector General activity
8. Medicare/Medicaid sanction activity
9. Internal information gathered during Ongoing Monitoring such as data from grievance and appeals, complaints, results of quality reviews, utilization management reviews and satisfaction surveys, as applicable.

**Health Delivery Organizations (HDOs):**

Each HDO applying for continuing participation in Anthem's programs or networks will be reassessed on at least a three year cycle.

In performing re-credentialing review all HDOs will be evaluated for the status of their licensure and accreditation. HDOs which have appropriate state licensure without sanction, probation or other adverse action and which have maintained accreditation by an agency recognized by Anthem (see Credentialing Policy #4.1) will be viewed as meeting all criteria and will be classified in the re-credentialing process as Level I providers (See Credentialing Policy #4.1). Level I HDO's may be approved by the chair/vice-chair of the CC or a medical director designee as noted in Credentialing Policy #3.

**Non-accredited HDOs:** in the absence of this accreditation, HDOs must meet exception criteria as outlined in Credentialing Policy #4.1 (Professional Competence and Conduct Criteria - Health Delivery Organizations).

Upon request, HDOs will be provided with the status of its credentialing application.

Anthem may request and shall accept additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The credentials committee will review this information along with the rationale presented and determine if either a material omission has occurred or if credentialing criteria are met.

Non-discrimination Policy

Anthem will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or health care providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Members to meet their needs and preferences, this information is not required in the credentialing or re-credentialing process.

Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence (See Credentialing Policy #8). Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing and re-credentialing process. Anthem will review denials and terms for consistency and lack of discrimination annually to identify discriminatory practices in re-credentialing practitioners. These reviews are documented in a report summary format by reason for the denial or term for initial denials, recredentialing, terminations, and off-cycle terminations. The reasons for denial or term include: not board certified, license/board action, malpractice, education/training, hospital privileges, criminal conviction, DEA, hospital action, insurance, work history gap, and federal sanctions. Should discriminatory practices be identified through annual review or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

In further effort to prevent and take proactive steps to protect against discrimination in the re-credentialing process, adherence to Anthem's nondiscrimination policy is reinforced at Credentials Committee meetings via inclusion of the following statement on each agenda:

As a Committee member, I will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or health care providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities, which are provided to the members to meet their needs and preferences, this information is not required in the recredentialing process. Credentials committee members' decisions are based on issues of professional conduct and competence as reported and verified through the re-credentialing process.

## Policy 10: Termination and Immediate Termination

Practitioner's or HDO's participation in Anthem's programs or networks may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence credentialing criteria, involving licensure (revocation, suspension or surrender), required medical staff Membership, privileges, Certification or accreditation. Additionally, a Practitioner's or HDO's participation in Anthem's programs or networks may be reassessed when Anthem receives information relative to professional conduct and competence including but not limited to a history of professional disciplinary actions, malpractice history, sanctions under Medicare, Medicaid or FEHBP, unprofessional conduct, moral turpitude, criminal convictions, reportable malpractice actions, loss or surcharge of malpractice insurance, or other events which affects or could adversely affect the health or welfare of a patient reasonably calling into question the Practitioner's or HDO's ability, capacity or intent to deliver efficient, quality patient care.

Actions adverse to a Practitioner's or HDO's continued participation in Anthem's programs or networks which are not based on concerns related to professional qualifications are not addressed in this policy, except to the extent that such practices may have been determined to be unprofessional conduct and/or competence by Anthem Credentials Committee (CC). Examples of such actions not addressed in this policy are those related to network over capacity, or unsatisfactory business or billing practices. These are viewed as Administrative Actions.

Additionally, whenever a Practitioner's or HDO's conduct requires that immediate action be taken as continued participation in Anthem's programs or provider network(s) poses an imminent risk of harm to Anthem's Members or if the Practitioner's license is suspended, probated or revoked, or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, a process for immediate termination may be invoked.

**Procedures**

A. Terminations:

If upon re-credentialing review or off-cycle review, the CC renders a decision of suspension or termination for cause, the practitioner (or HDO) shall be so notified and advised of the right to appeal the determination. If the practitioner (or HDO) invokes the right to appeal, the Provider (or HDO) shall be provided an appeal in accordance with procedure set forth in Credentialing Policy Appeals. If the practitioner (or HDO) does not invoke the right to an appeal or the appeals process upholds the CC's decision to suspend, terminate, the practitioner (or HDO), along with appropriate internal Anthem departments, shall be notified of the effective date of the termination.

B. Immediate Termination:

1. Routine issues regarding a Practitioner's or HDO's professional conduct and/or competence shall be reviewed by the chair/vice-chair of the CC and referred to the CC for review. However, when Anthem receives information that a Practitioner's or HDO's continued participation in Anthem's programs or provider network(s) may pose some potential risk to the health or welfare of one or more of Anthem's Members or may potentially result in imminent danger to the health or welfare of one or more of Anthem's Members due to specific issues of professional conduct and competence or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, a process for immediate termination exists. In such instances, the chair/vice-chair of the CC and/or Anthem Medical Director or designee, after consultation with legal counsel, may terminate the Practitioner's participation in Anthem's programs or provider network(s), effective immediately and provide notice to the practitioner or HDO. The investigation in support of such immediate termination may occur in an expedited timeframe. The practitioner or HDO shall be sent a written statement, by certified mail, of this decision.
2. When the process for Immediate Termination is invoked, the action will be reported and reviewed and the next scheduled meeting of the Credentials Committee.
3. The practitioner (or HDO) may have the right to appeal, but participation may not be reinstated during the appeals process. If a decision to immediately terminate a practitioner (or HDO) is overturned on review or appeal, the practitioner (or HDO) shall be reinstated, and will not lose any of the protections to which practitioner (or HDO) had been entitled before the Immediate Termination. These include the exemption from criteria such as Certification or accreditation based on their prior participation.

C. Reporting:

Anthem shall comply with the reporting requirements of state licensing agencies and the National Practitioner Data Bank, the Federal Healthcare Quality Improvement Act (Title IV of Public Law 99-660) regarding adverse credentialing and Peer Review actions, and/or other organizations as required by law.

## Policy 11: Report of Adverse Actions

The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies.

In the event that the procedures set forth in this Policy for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook, the process set forth in the NPDB Guidebook will govern.

**Procedures**

A. Reporting

1. When a Professional Review Action is taken by Anthem with respect to a professional Provider's participation in one or more Anthem networks, Anthem may have an obligation to report such to the NPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board.

   NPDB. Professional Review Actions of providers shall be reported electronically to NPDB as applicable and in writing to the applicable state licensing board, if required, following that state's requirements for filing a written report. (Institutional Providers are not subject to this reporting requirement). The report shall be filed with the state licensing board if required, and NPDB as applicable, no later than 15 days of the earlier of (a) the effective date of the providers immediate contract termination due to imminent danger to an individual's health and safety; or (b) the exhaustion of the providers appeal rights and the date the adverse Professional Review Action has been made final.

   Notwithstanding the foregoing, Anthem may report the matter to other appropriate governmental or private organizations, provided such reporting is approved in advance by the Legal Department in conjunction with consultation with the Special Investigations Unit.

2. If Anthem, in its discretion, accepts a Provider's voluntary resignation or without cause termination in lieu of Anthem's termination of the Provider for any reason that would otherwise lead to a Professional Review Action then Anthem may have a reporting obligation despite the fact that a Formal Appeal was not offered. Thus, the Legal Department must be consulted prior to any without cause terminations or prior to accepting any voluntary resignations for reasons other than retirement, the Provider moving from the area, or other reason that is not truly for cause.

3. Any report made under this Policy and Procedure shall only include the minimum necessary information to fulfill Anthem's reporting obligation.

4. Anthem's failure to report as required under applicable laws can result in fines and Civil Monetary Penalties against Anthem.

5. Anthem shall protect from disclosure any information that it reports to or receives in a report from NPDB or state licensing board.

6. All Professional Review Actions must be reviewed by the Legal Department in advance of any report to the state licensing board or NPDB.

7. The Credentialing Manager/Director is the Anthem authorized representative for initiating the reporting of adverse actions. The Anthem's credentialing staff will compile the necessary information following Anthem Credentials Committee action and submit the appropriate forms for review by the Anthem's legal counsel. After review and confirmation by legal counsel, the Credentialing Manager/Director will notify via IQRS the state licensing agency, NPDB as required by law. The Chair of the CC will have final approval and signature on all Adverse Action Reports when required or appropriate. All reports made to NPDB shall be in accordance with the current guidelines established for such databank.

B. Reporting Requirements to the National Practitioner Data Bank

All providers are subject to reporting of adverse actions. In addition, other allied health professionals may be subject to reporting under certain circumstances. Full description regarding requirements for allied health professionals is available on the internet at https://npdb.hrsa.gov.

All reports to the NPDB must be submitted electronically. Reports will be submitted via the Internet using the Integrated Querying and Reporting Service (IQRS) or on diskette in a format specified by the NPDB. Details on the format specified for submissions may be obtained by calling the NPDB Help Line at 1-800-767-6732.

Anthem will notify the State Licensing Agency on the Adverse Action Report form (available electronically to NPDB authorized entities) within 15 days of the date of any final reportable action taken against a practitioner for a period longer than 30 days that adversely affects the Practitioner's participation in the Anthem's programs or networks, any voluntary surrender of participation or privileges by a practitioner under investigation by the Credentials committee for possible incompetence or improper professional conduct, or voluntary surrender of participation or privileges by the practitioner in lieu of such investigation.

Prior to mailing the Adverse Action Report to the applicable State Agency, the form must, at a minimum be, reviewed by the Anthem's legal counsel and Medical Director. Once the form has been reviewed by the Anthem's legal counsel, Medical Director and any other appropriate parties, the Anthem's credentialing staff will mail the form via Certified/Return Receipt Requested and stamped "Confidential".

C. Reporting Errors, Omissions, and Revisions

1. Any errors/omissions to an Adverse Action Report found after a report has been filed with the State Agency and/or the NPDB must be sent to the State Agency and/or NPDB as soon as possible to prevent the disclosure of any inaccurate or incomplete information.
2. If errors or omissions are found after information has been reported, corrections must be submitted via IQRS. When the NPDB processes a correction submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a correction is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Report Revised, Voided, or Status Changed document is mailed to the subject of the report and all queries who received the previous version of the report within the past 3 years. Anthem and the practitioner should review the information to ensure that it is correct.
3. If errors or omissions are found after information has been reported to State Licensing Agency, corrections must be submitted by annotating the "Report Verification Document" or by submitting a new, fully completed "Adverse Action Report" form. There are two categories of changes to an "Adverse Action Report," CORRECTION OR ADDITION and VOID PREVIOUS REPORT. A CORRECTION OR ADDITION supersedes, or adds information to, the current version of a report. A VOID PREVIOUS REPORT retracts a report in its entirety, and the report is treated as though it had not been submitted (i.e., a report was made on the wrong Practitioner)
4. A "Revision to Action" is a new action that is related to and modifies a previously submitted adverse action. If adverse action information was reported, then any revisions to that action must also be reported. When the NPDB processes a Revision to Action submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a Revision to Action is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Notification of a Report

in the NPDB is mailed to the subject of the report. Anthem and the practitioner should review the information to ensure that it is correct.

5. Revisions are subject to the same time constraints and procedures as the initial action. Revisions include reversal of a Professional Review Action or reinstatement of the Practitioner's participation in Anthem's programs or networks.

D. NPDB Reporting Questions:

Then questions arise regarding querying or reporting requirements, the Compliance Staff will call the NPDB Hotline for assistance at 800-767-6732. The calls will be documented with date and time, person spoken to, and a brief narrative of the call. Assistance from the Anthem's legal counsel will also be sought as necessary.

## Policy 12: Ongoing Sanction Monitoring

Credentialing associates perform ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within 30 days of the time they are made available from the various sources including, but not limited to, the following:

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

External sources (1-4) will be queried every 6 months if they do not publish information on a set schedule. For these sources, the review will take place when the oversight entity has come to its final determination including but not limited to: Probations, Sanctions, Warnings, Public Notices of Poor Performance, or Reprimands. Interim determinations indicating that a case is under investigation will not be reviewed until a determination has been issued.

Internal sources (5-8) used to review complaints and adverse events will be queried every 6 months if they do not provide information on a regular schedule that is more frequent than this.

When a participating practitioner or HDO has been identified by these sources, credentialing criteria will be used to assess the appropriate response. These responses include, but not limited to: review by the Chair of the Anthem's Credentials Committee (CC), review by the Anthem's Medical Director, referral to the CC, or termination.

### Procedures

Credentialing staff will review information from the previously referenced external sources as well as periodic information submitted by internal departments to the credentialing department.

A. Sanction Monitoring

If information regarding a participating practitioner or HDO is identified in an external source, the Practitioner's or HDO's applicable credentialing information will be forwarded to the Chair of the CC, or Anthem Medical Director or designee to determine the urgency of the need for response. If urgent action is required, the practitioner or HDO may be subject to the Immediate Termination process. If urgent action is not required, the Practitioner's or HDO's file will be prepared for the next scheduled CC meeting. Anthem may request additional documentation from the reporting agency and/or the Provider at any point in the monitoring process. The issues will be reviewed in light of predetermined criteria, either credentialing eligibility standards, or performance monitoring standards.

B. Performance Monitoring

Anthem's credentialing department will incorporate internal information regarding a Practitioner's performance in the ongoing monitoring process whenever such information is available.

1. Sources for this include, but are not limited to
    a. Quality Improvement activities,
    b. Quality Reviews of complaints from any credible source,
    c. Individual case review performed by internal quality departments,
    d. Adverse events or outcomes review
    e. Medical records reviews
    f. Member's complaints and grievances.
2. For recurrent information types, the applicable Anthem's quality review committee may establish specific thresholds that may indicate problems with professional conduct and competence
3. All referrals from internal sources will have been reviewed by an appropriate internal Anthem review committee prior to their submission to the credentialing department. These will be referred to credentialing when the results of that internal review are such that consideration of formal credentialing action is warranted.
4. Internal sources may be queried periodically or internal departments may provide reports on a periodic basis to detect any trends, problems and issues regarding individual practitioners or HDOs.
5. If the credentialing staff determines that the practitioner or HDO has exceeded predetermined thresholds as described above, the Practitioner's or HDO's credentialing information will be reviewed with the Credentialing Manager and the Manager of the department making the report, or his or her designee. This review should include all information from the reporting department, any corrective actions, plans, and correspondence sent to the practitioner or HDO from the reporting department to help ensure that the appropriate internal Anthem quality review committee has occurred and that the referral to credentialing is appropriate
6. All the information obtained pursuant to this review will become part of the Practitioner's or HDO's credentialing information and be forwarded for review by the Chair of the CC or designee. The Chair of the CC or designee will review the file to determine if the issues of professional competence or conduct are of an urgent nature to warrant Immediate

Termination. If the issues do not warrant Immediate Termination, the Provider is referred to the CC.

## Policy 13: Appeals – Practitioners

Initial applicants denied network participation may submit additional information as an Informal Review/ Reconsideration. In those limited instances when the refusal of network participation results in a unique NPDB report by Anthem, the initial applicant may also pursue a Formal Appeal.

Participating practitioners whose network participation has been terminated for professional conduct and competence reasons by Anthem's Credentialing Committee (CC), including immediate termination imposed due to Anthem's determination that the Practitioner's continued participation poses an imminent risk of harm to the Anthem's Members, or when termination requires a unique report to the NPDB may request an Informal Review/Reconsideration as well as pursue a Formal Appeal.

Participating practitioners whose network participation has been terminated due to an Adverse Administrative Action or for professional conduct and competence reasons which do not require CC review (e.g., failure to obtain board certification, lack of hospital privileges) are eligible for Informal Review/Reconsideration but not eligible for Formal Appeal.

Participating practitioners whose network participation has been terminated due to the Practitioner's suspension or loss of licensure or due to criminal conviction are not eligible for Informal Review/Reconsideration or Formal Appeal.

Participating practitioners whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

**Procedures**

Informal Review/Reconsideration.

A. Notice

1. Terminations of Participating Providers

   When participation was terminated for professional conduct and competence reasons by Anthem's CC or when termination requires a report to the NPDB, the credentialing staff will notify the practitioner via certified letter of the decision. The notice will contain:

   a. the reason for the decision,
   b. statement that the practitioner has the opportunity for an Informal Review/ Reconsideration of the decision and that the practitioner has the right to submit additional information to Anthem to correct any errors in the factual information which led to the determination or provide other relevant information, and
   c. a summary description of the Informal Review/Reconsideration, and
   d. a statement that the practitioner has the right to waive the Informal Review and proceed directly to a Formal Hearing, and the consequences of waiving this right, and
   e. a statement that the practitioner must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the practitioner wishes to be considered.

2. Denial of Initial Applicants

   When initial application is rejected by Anthem's CC, the credentialing staff will notify the practitioner via certified letter of the decision. The letter will contain: the reason for the decision, a statement that the practitioner has the opportunity for an Informal Review/Reconsideration of the decision and that the practitioner has the right to submit additional information to Anthem to correct any errors in the factual information which led to the determination or provide other relevant information, and a statement that the practitioner must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the Credentialing Department for a review of the decision, along with any additional information the provider wishes to be considered.

   **Note:** A request for an Informal Review/Reconsideration shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract.

B. Request for Reconsideration/Informal Review

   The practitioner may request a Reconsideration/Informal Review of a CC decision which is adverse to the Practitioner's network participation. This request must be in writing, sent via certified mail, and received by the credentialing department within thirty (30) calendar days (unless otherwise required by state regulation) of the date the practitioner received the letter from Anthem with its determination based on the committee results or the Practitioner will forfeit his or her right to request a Reconsideration/Informal Review.

C. Process

   Additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/ Reconsideration along with the information used as the basis for the initial decision and forwarded to the CC for review at its next meeting. The practitioner under review may provide written information, but is not present during the CC meeting. For initial determinations, if the information submitted by the practitioner contains no new objective information, it may be presented in summary form.

D. Reconsideration/Informal Review

   The CC will review the additional information submitted by the practitioner along with the information obtained during the initial credentialing or re-credentialing process and the basis for its initial decision at a regularly scheduled CC meeting or at a special review meeting. The CC will then determine whether to uphold or overturn its initial decision.

E. Review Results

   The CC decision on the Reconsideration/Informal Review is reported to the credentialing department within five (5) business days of its decision. The credentialing staff then notifies the practitioner via certified mail within fourteen (14) calendar days of the decision. For practitioners requesting Reconsideration/Informal Review of a denial for initial participation in Anthem's networks this is the final level of review, unless Anthem's action is to be reported to the NPDB. Whenever an action is to be reported to the NPDB, the practitioner will be afforded the right to a Formal Appeal.

F. Notice

   The notice of the outcome of the Reconsideration/ Informal Review will contain:

   1. The reason for the decision;

2. Where a practitioner is eligible for Formal Appeal, a statement that:
    a. The practitioner has the opportunity to submit additional information to the Anthem for appeal of the decision; and
    b. A summary description of the appeal process described below.
3. A statement that, if the practitioner desires an appeal, the practitioner must submit, within the thirty (30)- calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
    a. A written request to the credentialing department for an appeal of the decision; and
    b. Any additional information the practitioner wishes to be considered.

    When the practitioner is eligible for and requests a Formal Appeal, the effective date of the termination, unless otherwise required by state law or regulation or by contract, will be delayed until the date the Formal Appeal hearing decision is rendered or a decision not to continue pursuing a hearing is communicated by the practitioner to credentialing staff.

Formal Appeal

A. Formal Appeal Hearing, Upon Request.

A practitioner who has been terminated from the network or whose denial for initial participation will be reported to the NPDB may request a formal appeal hearing. This request must be in writing and received via certified mail within the thirty (30) calendar day period immediately following the date of the Practitioner's receipt of the notice from Anthem otherwise he or she will forfeit his or her right to a hearing. If a practitioner timely requests a hearing, the following procedures will be followed:

1. The credentialing staff will notify Anthem's medical director, and Anthem's legal counsel, of the Practitioner's request for a hearing.
2. Hearing Panel. Anthem's medical director or designee will select the members of the hearing panel. The hearing panel will be comprised as set forth below unless other panel criteria may be required under applicable law:
    a. Three (3) to seven (7) practitioners not involved in the original decision:
        i. Must be credentialed and by Anthem and in good standing;
        ii. The hearing panel will be chaired by Anthem's Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel;
        iii. May not be the same individual who chair or vice-chairs the geographic CC;
        iv. No person who is in direct economic competition with the practitioner may serve on the hearing panel; and
        v. Only hearing panel members not involved in the original decision may vote.

    At least one of the hearing panel members will be a Clinical Peer.
3. Additional hearing panel criteria for physicians that participate in Medicare Advantage (MA) products:
    a. The majority (e.g. two out of a typical 3 member panel) of the hearing panel members will be Clinical Peers.

4. Hearing Notice. Within thirty (30) business days of receipt by Anthem of a Practitioner's request for a Formal Appeal, the credentialing staff will send a certified letter notifying the practitioner of the date, time, and place of the formal hearing. It will advise the practitioner that he/she may appear by telephone, videoconference, or in person (when available) or by telephone. This letter will also summarize the hearing procedures and notify the practitioner that he or she may appear with a legal representative or other designee before the hearing panel, and that such practitioner has the right to:
    a. have a record made of the proceedings, copies of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof;
    b. call, examine, and cross-examine witnesses;
    c. present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
    d. be represented by an attorney or another person of their choice;
    e. submit a written statement at the close of the hearing; and
    f. receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision.
    g. Such notice will also state that the practitioner will forfeit his or her right to a hearing if the practitioner (1) does not respond to the notice to confirm the date, time, and place of the formal hearing within fourteen (14) business days following receipt of the notice by the Provider (2) cancels within seven (7) days of the scheduled hearing without good cause; or (~~2~~ 3) fails to attend the scheduled hearing (either in person or by telephone) without good cause. Hearings may be rescheduled a maximum of two (2) times, unless good cause is provided. If a practitioner has forfeited his or her right to a hearing, the Adverse Credentialing Decision with stand.
5. In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial and/or termination letter originally sent to the applicable Practitioner. The panel members may also be provided with any other material deemed relevant by Anthem at or in advance of the hearing.
6. Hearing Date. The hearing date will be not less than 30 nor more than 60 calendar days after the date of the notice given to the practitioner of the date, time, and place of the formal hearing or as otherwise agreed to by Anthem and the affected Practitioner.

B. Hearing Procedures.

The chairperson of the hearing panel, who is an Anthem medical director or his or her designee, will open the hearing by stating the purpose and protocol of the hearing.

1. During the hearing, the practitioner will have the ability to exercise any or all of the rights set forth in Section 1(d), Hearing Notice above.
2. A representative of Anthem will present the reasons for the decision to reject or terminate the Practitioner.
3. The practitioner will present reasons why his or her participation should not be rejected or terminated.
4. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.

5. The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period.
6. The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold, reject, or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.
7. The hearing panel will prepare a written decision, including the rationale, for its decision.

C. Review Results and Notice

Anthem's medical director shall report the decision of the hearing panel to the credentialing department within five (5) business days of the date of the hearing. The credentialing staff shall notify the practitioner via certified mail, return receipt requested, within ten (10) calendar days of receiving notification from the medical director of the hearing panel's decision and rationale.

Reporting Final Adverse Actions:

Anthem will report any final adverse actions in accordance with Credentialing Policy.

For those practitioners and practitioners participating in a Medicare Advantage Network, the Formal Hearing will follow this rule:

A. Formal Hearing, Upon Request.

1. Hearing Panel.

When the practitioner requesting the Formal Hearing is a physician in the Medicare Advantage program, the Anthem medical director or designee will select the of the hearing panel. The hearing panel will be comprised of at least three (3) practitioners not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person who is in direct economic competition with the practitioner may serve on the hearing panel. Two of the hearing panel members will be clinical peers. The hearing panel will be chaired by the Anthem's medical director, or designee, who is entitled to vote and who is counted as a member of the hearing panel.

## Policy 14: Appeals – Facilities

It is the intent of Anthem to give HDOs the opportunity to appeal a termination of the HDOs participation in one or more of Anthem's provider network(s) or programs. Immediate terminations may be imposed due to the HDOs loss of licensure, criminal conviction of one of the principal officers of the HDO or Anthem's determination that the HDOs continued participation poses an imminent risk of harm to Anthem's Members, or the HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs. An HDO whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal. An HDO whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

**Informal Review/Reconsideration:**

Notice: Terminations of Participating Providers:

Upon decision by the geographic CC to terminate a HDO's participation, the credentialing staff will notify the HDO via certified letter of the decision. The notice will contain the reason for the decision, a

statement that the Provider has the opportunity for an Informal Review/ reconsideration of the decision, a statement that the provider has the right to submit additional information to Anthem for Informal Review/Reconsideration and a summary description of the review process described below. In addition, the notice will also advise that the HDO has the right to waive the Informal Review thus proceeding to a Formal Hearing, and that proceeding directly to a Formal Hearing waives any future right to an Informal Hearing. The notice also will state that if the Provider desires any further review, the HDO representative must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the Provider wishes to be considered. A request for any additional review shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract. For information regarding immediate terminations, see Credentialing Policy #10.

A. Request for Reconsideration/Informal Review:

   The HDO may request a Reconsideration/Informal Review of the geographic CC's decision if the decision of the geographic CC is adverse to the provider. This request must be in writing, sent via certified mail, and received by the credentialing department within the thirty (30) calendar day period immediately following the date of the HDO's receipt of the letter from Anthem (unless otherwise required by state regulation), with its determination based on the committee results. (See "Appendix A" for those plans with Meet and Confer Language in Provider Contract)

B. Process:

   Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/Reconsideration. The credentialing staff will review the information used as the basis for the initial decision, along with any additional information submitted by the HDO and if appropriate, forward the matter including any additional information submitted by the HDO to the geographic CC at its next meeting. No representatives of the HDO shall be present during the Informal Review/Reconsideration. For initial determinations, if the information submitted by the HDO contains no new objective information, it may be presented in summary form.

C. Informal Review/Reconsideration:

   As reconsideration, any additional information submitted subsequent to the initial decision of the geographic CC will be presented to the committee for its consideration. All of the conditions of Credentialing Policy #3 with regards to the geographic CC apply. The geographic CC will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the HDO. This review may take place at regularly scheduled geographic CC meeting or at a special review meeting. The representatives of the HDO shall not be present during the review. Anthem may have credentialing staff, network service representatives and legal representatives present for the first level review as non-voting members.

D. Review Results:

   The geographic CC shall report its decision on the Reconsideration/Informal Review to the credentialing department within five (5) business days of its decision. The credentialing staff shall notify the HDO via certified mail within fourteen (14) calendar days of the decision.

**Formal Appeal Process:**

Notice:

1. Upon notification that Reconsideration/Informal Review of a decision to terminate an HDO's participation of a Professional Review Action was upheld by the geographic CC, the credentialing staff will notify the entity via certified letter of the decision. The notice will:
    a. Contain the reason for the decision;
    b. Where an HDO is eligible for Formal Appeal, a statement that:
        i. The HDO has the opportunity to submit additional information to Anthem for appeal of the decision; and
        ii. A summary description of the appeal process described below.
    c. State that if the HDO desires an appeal, the entity must submit, within the thirty (30)-calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
        i. Written request to the credentialing department for an appeal of the decision; and
        ii. Any additional information the HDO wishes to be considered.
2. A request for a Formal Appeal shall stay the effective date of the termination, unless otherwise required by state law or regulation or by contract.

Formal Appeal Hearing, Upon Request:

A HDO which has been terminated from the network may request a formal appeal hearing if the decision of the first level review is adverse to the HDO or if the right to first level review was waived by the HDO. This request must be in writing and received via certified mail within the thirty calendar (30) day period immediately following the date of the HDO's receipt of the notice from Anthem. If an HDO timely requests a hearing, the following procedures will be followed:

The credentialing staff will notify Anthem' Medical Director, and Anthem's legal counsel, of the Provider's request for a hearing.

Hearing Panel:

Anthem Medical Director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three (3) individuals not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person with an economic interest in an entity in direct competition with the appealing HDO may serve on the hearing panel. At least one of the hearing panel members will be a participating provider with some experience with the type of HDO in question, but without any other role in network management. The hearing panel will be chaired by Anthem's Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel.

Hearing Notice:

Within thirty (30) business days of receipt by Anthem of a request for a Formal Appeal, the credentialing staff will send a certified letter notifying the HDO of the date, time, and place of the formal hearing. It will advise the representatives of the HDO that it may have its representative appear by telephone, videoconference, or in person (when available). This letter will also summarize the hearing procedures and notify the HDO representative that he or she may appear with a legal

representative or other designee before the hearing panel, and that the entity and its representatives have the right to:

1. Have a record made of the proceedings, copies of which may be obtained by representative(s) of the HDO upon payment of any reasonable charges associated with the preparation thereof;
2. Call, examine, and cross-examine witnesses;
3. Present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
4. Be represented by an attorney or another person of their choice;
5. Submit a written statement at the close of the hearing;
6. Receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision.

   Such notice will also state that the HDO will forfeit its right to a hearing if the representative(s) of the HDO: (1) does not respond to the notice to confirm the date, time, and place of the formal hearing within fourteen (14) business days following receipt of the notice by the representative(s) of the HDO; (2) cancels within seven (7) days of the scheduled hearing without good cause; or (3) fail(s) to attend the hearing without good cause or request a hearing within thirty (30) days. If a HDO has forfeited the right to a hearing, the Adverse Credentialing Decision with stand.

   In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial and/or termination letter originally sent to the applicable HDO. The panel members may also be provided with any other material deemed relevant by Anthem at or in advance of the hearing.

Hearing Date:

The hearing date will be not less than thirty (30) nor more than sixty (60) calendar days after the date of the notice given to the HDO of the date, time, and place of the formal hearing or as otherwise agreed to by Anthem and the affected HDO.

A. Hearing Procedures:

   The chairperson of the hearing panel, who is the Medical Director or their designee, will open the hearing by stating the purpose and protocol of the hearing.

   1. During the hearing, the HDO representative will have the ability to exercise any or all of the rights set forth in Section “Hearing Notice” above.
   2. A representative of Anthem will present the reasons for the decision to reject or terminate the HDO.
   3. The representative of the HDO will present reasons why his or her participation should not be rejected or terminated.
   4. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.
   5. The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period.
   6. The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the

authority to uphold, reject, or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.

7. The hearing panel will prepare a written decision, including the rationale, for its decision.

B. Review Results:

Anthem's Medical Director shall report the decision of the hearing panel to the credentialing department within five (5) business days of the date of the hearing. The credentialing staff shall notify the HDO via certified mail, return receipt requested, within ten (10) calendar days of receiving notification from the Medical Director of the hearing panel's decision and rationale.

C. Reporting Final Adverse Actions:

Anthem will report any final adverse actions in accordance with applicable local regulations.

## Policy 15: Reapplication after Termination or Denial

The timeline that permits practitioners or HDOs the opportunity to reapply for participation in one or more of the Anthem's programs or networks, after a Professional Review Action has been taken by the Anthem Credentials Committee (CC) to deny or terminate the Practitioner's or HDO's participation varies depending upon the issues involved and is set forth herein. This policy is not intended to define reapplication time frames for denials or terminations taken for administrative and/or business reasons.

Nothing in this Policy requires Anthem to automatically accept previously denied or terminated practitioners. Practitioners and HDOs reapplying for participation or requesting reinstatement in one or more of Anthem's programs or networks, must complete an application, meet current participation criteria, and be approved by the CC.

**Provider Procedures**

A. Failed site visit (where applicable):

A practitioner (or HDO) may reapply once the location undergoes a site visit by Anthem, or its designee, that meets Anthem's standards.

B. Physical/mental impairment:

A practitioner may reapply upon Anthem's receipt of documentation from the Practitioner's treating physician that the practitioner is physically and mentally capable to perform within the scope of practice for which application is made and that the Practitioner's status does not suggest future probable substandard professional conduct and competence.

C. Suspension of hospital privileges:

A practitioner may reapply upon Anthem's receipt of documentation from the hospital or other applicable authority that the action has been cleared OR may reapply after a period of one (1) year after the final action and the practitioner has privileges at an appropriate Professional.

D. Chemical/Substance Use Disorder:

Reapplication may occur when either one of the following are met whichever occurs first:

1. If this licensing agency has taken action related to substance use disorder, a practitioner may reapply after a period of one year of active participation in a treatment program, with receipt of a statement or other legally required documentation from the Practitioner's supervising physician and any applicable State required program for impaired practitioners. This statement

must indicate that the practitioner is in a successful maintenance program with no evidence of recidivism and the Practitioner's status does not suggest future probable substandard professional conduct and competence. OR

2. A practitioner may reapply upon removal of all licensure encumbrances, have been removed.

E. Falsification on application or supporting documentation:

A practitioner or HDO may reapply one (1) year after the occurrence.

F. Restricted DEA and/or State Certification:

A practitioner or HDO may reapply upon Anthem's receipt of documentation from the applicable authority that the restrictions have been lifted.

G. License Sanctions:

A practitioner may reapply upon Anthem's receipt of documentation from the applicable authority that the license is no longer sanctioned/encumbered.

H. Other Quality Issues:

A practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.

I. Malpractice History:

A practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.

J. Felony Convictions:

A practitioner may reapply after a period of one (1) year has elapsed from the date of the conviction or conclusion of sentencing, incarceration/obligation, whichever is later.

K. Federal Sanctions:

A practitioner or HDO may reapply once the sanction is lifted.

L. Other Issues of Professional Conduct or Competence:

A practitioner or HDO may reapply after a period of one (1) year.

The CC retains, solely at its discretion, the right to reduce the period of time for the Provider to reapply.

## Policy 16: Practitioner Physical & Mental Health Conditions and Impairments

The purpose of this policy is to provide guidelines for credentialing, recredentialing or interim assessments by the Credentialing Committee of practitioners (whether current Participating practitioners or applicants) to whom any of the following apply: 1) are acknowledged to have a mental health or substance use disorder Condition; or 2) have undergone treatment for a mental health or substance use disorder Condition in the past three years ;or 3) have a physical impairment that may negatively impact their ability to provide care to patients or pose a risk of harm to patients. Information regarding presence or history of a Mental Health Condition(s), substance use disorder Condition, and/or physical condition(s) and/or impairment(s) is found through disclosure on the Practitioner's application for participation in a network, through primary source verifications or databank queries in the process of credentialing, or other credible sources.

A. Practitioners (whether current Participating practitioners or applicants) who are identified as having a mental health or substance use disorder Condition or conditions for which they are currently undergoing treatment or for which they have undergone treatment in the past three years, or identified to have a physical condition(s) and/or impairment(s) that could interfere with their ability to perform the scope of care expected by a practitioner in their Specialty or whose condition could pose a risk of harm to enrollees will be individually reviewed by the Credentialing Committee.

B. Practitioners (whether current Participating practitioners or applicants) and who have issues related to substance use disorder must provide information that they he/she is currently in or has successfully completed an ongoing treatment and/or monitoring program. The information reviewed must not raise a reasonable suspicion of substandard professional conduct and competence, or that the Practitioner's history does not adversely affect patient safety.

C. For initial applicants, the criteria related to license status discussed in prior criteria is applicable.

D. For initial applicants who disclose information regarding substance use disorder or other impairment and whose license status has not been affected, the Credentials Committee shall use discretion to determine what constitutes a satisfactory length of time in a treatment or a reasonable practice setting.

E. For Participating practitioners whose license status has been affected because of substance use disorder, the information must indicate a documented period of no less than one (1) year since initiation of a successful, supervised treatment in a program with no evidence of recidivism since that time.

F. For Participating practitioners with substance use disorder or other impairments whose license has not been affected by the substance use disorder issue or impairment, the Credentials Committee shall use discretion to determine what constitutes a satisfactory length of time in a treatment or monitoring program and may then require documentation in support of that requirement.

G. In any instance where there is reasonable concern regarding impairment, the Credentials Committee may, at its discretion require whatever additional monitoring or follow up information it deems appropriate.

H. Practitioners who fit the descriptions noted above may be asked to have their treating physician submit directly to the Credentialing Department, information noting whether their condition in any way impairs their ability to practice or in any way poses a risk of harm to patients or raises a reasonable suspicion of substandard professional conduct or competence. Practitioners will be required to authorize the release of such information to the CC in order for the participation to be evaluated. Additionally, the treating physician will be asked to agree to notify the Credentialing Department if, at any time during treatment of the Practitioner, it becomes apparent that the Practitioner’s condition could impair the Practitioner’s ability to practice or could pose a risk of harm to patients.

I. The information obtained will be considered when the Credentialing Committee makes its decision regarding network participation.

**Procedures**

A. When information is received that a Practitioner:

1. Has a Mental Health Condition and is currently undergoing treatment or has undergone treatment in the past three years, or
2. Has a medical condition or impairment affecting his or her ability to perform his or her professional duties or when such information is found through primary source verifications or databank queries in the process of credentialing, or
3. Is undergoing treatment for, or has a history of, substance use disorder.

B. The practitioner may:

   Be advised, in writing, that to be considered for network participation (new or continued) it will be necessary for the practitioner to authorize their treating physician to provide written substantiation to the Credentialing Department noting whether the Practitioner's condition in any way impairs their ability to practice or could pose a risk of harm to patients or suggest future probable substandard professional conduct or competence.

C. Once the letter from the treating physician is received, information from the Practitioner's application, including documentation from the treating physician will be individually reviewed by the Credentialing Committee.

## Policy 17: Specialty Designations

A. Anthem recognizes all provider specialty designations recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA), the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). Additionally, specialties not recognized by the ABMS, AOA, RCPSC or CFPC but for which the Accreditation Council for Graduate Medical Education (ACGME) has designated accredited training programs will be eligible for recognition if deemed acceptable by the National Credentials Committee.

B. For provider types which are in the scope of the credentialing program, but for which the ABMS/AOA/RCPSC/CFPC/ACGME is not applicable, the National Credentials Committee will establish acceptable education and training requirements for recognition (see below) Any specialty recognized by Anthem is eligible for use in provider directories, but determination of need for a specific eligible specialty designation is that of Anthem. In situations where there are extenuating or special circumstances an Access Needs Waiver must be completed and reviewed by the National Credentials Committee.

**Anthem recognized specialty types with education and training requirements:**

| Provider Type | Training Requirements |
|---|---|
| General Practice<br>NCC Approval date: 03/13/2015 | Meets the criteria outlined in Credentialing Policy #4.0. |
| Gynecology<br>NCC Approval Date: 12/21/05 | Same training as obstetrics/gynecology (4 years accredited graduate medical education in an Obstetrics/Gynecology program with no less than 36 months of clinical Obstetrics/Gynecology). This designation is per the applying physician's choice in place of, but in addition to, the designation of obstetrics/gynecology. |

| Provider Type | Training Requirements |
|---|---|
| Internal Medicine and Pediatrics<br>NCC Approval Date: 12/21/05 | 1. Board Certified in both Internal Medicine AND Pediatrics OR<br>2. Successful completion of a dual residency program in internal medicine AND pediatrics with the stipulation that certification in both Internal Medicine and Pediatrics will be obtained within five years. |
| Addiction Medicine<br>NCC Approval Date: 12/21/05 | ABMS recognized pathway through psychiatry, American Board of Preventive Medicine, or AOA certification. |
| Sleep Medicine<br>NCC Approved | Certification by a primary specialty board that is recognized by the ABMS or the AOA and 1 full year of additional training in Sleep Medicine (PGY 3 or later via a Fellowship in Sleep Medicine or through an equivalent training period in an alternate ACGME approve program such as training in Sleep Medicine that takes place in a fellowship program in Pulmonary Medicine or Clinical Neurophysiology). |
| Pediatric Orthopedics<br>NCC Approval Date: 12/21/05 | Completion of a recognized ACGME training program in Pediatric Orthopedics OR Board Certified in Orthopedics and having privileges in orthopedics at a pediatric specialty hospital. |
| Pediatric Urology<br>NCC Approval Date: 12/21/05 | Completion of a recognized ACGME training program in Pediatric Urology OR Board Certified in Urology and having urology privileges at a pediatric specialty hospital. |
| Pediatric Ophthalmology<br>NCC Approval Date: 12/21/05 | Board Certified in Ophthalmology and having privileges in ophthalmology at a pediatrics specialty hospital. |
| Pediatric Neurosurgery<br>NCC Approval Date: 12/21/05 | Board Certified in Neurosurgery and having privileges in neurosurgery at a pediatrics specialty hospital. |
| Pediatric Cardiac Surgery<br>NCC Approval Date: 12/21/05 | Board Certified in Cardiovascular Surgery and having privileges in cardiac surgery at a pediatrics specialty hospital. |
| Pediatric Allergy & Immunology<br>NCC Approval Date: 12/21/05 | Board Certified in Allergy & Immunology and two years training in Pediatrics. |
| Glaucoma<br>NCC Approval Date: 12/21/05 | Board Certified in Ophthalmology with one-year fellowship in Glaucoma at an institution with an ophthalmology residency program recognized by ACGME. |
| Retinal Disease<br>NCC Approval Date: 12/21/05 | Board Certified in Ophthalmology with one-year fellowship in Retinal Disease at an institution with an ophthalmology residency program recognized by ACGME. |
| Adult Reconstructive Orthopedics<br>NCC Approval Date: 12/21/05 | Board Certified in orthopedics and completion of a recognized ACGME in Adult Reconstructive Orthopedics. |
| Foot and Ankle Orthopedics<br>NCC Approval Date: 12/21/05 | Board Certified in orthopedics and completion of a recognized ACGME in Foot and Ankle Orthopedics. |
| Orthopedic Trauma<br>NCC Approval Date: 12/21/05 | Board Certified in orthopedics and completion of a recognized ACGME in Orthopedic Trauma. |
| Orthopedic Surgery of the Spine<br>NCC Approval Date: 12/21/05 | Board Certified in orthopedics and completion of a recognized ACGME in Orthopedic Surgery of the Spine. |

| Provider Type | Training Requirements |
|---|---|
| Pain Medicine<br>NCC Approval Date: 12/21/05 | Board Certification in Pain Medicine through ABMS or AOA recognized process or Board Certification by the American Board of Pain Medicine |
| Hematology/Oncology<br>NCC Approval Date: 07/10/09 | Completion of a recognized ACGME training program in Hematology and Oncology with board certification in both Hematology and Oncology or AOA recognized process. |
| Developmental-Behavioral Pediatrics | Board certification in Developmental-Behavioral Pediatrics subspecialty through American Board of Pediatrics. Prior to ABMS approval in 1999: completed a two-year Developmental Behavioral Fellowship and documentation of accepted application to sit for the subspecialty board of Developmental-Behavioral Pediatrics or an attestation from fellowship director that fellowship was completed and training is sufficient. |

## Attachment A: Practitioner Types and Specialties Not Requiring Hospital Privileges

Hospital Privilege requirements apply in general to physician providers, and thus the following provider types are excluded from this requirement. These practice types include:

1. Chiropractors
2. Podiatrists
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/ Counselors, Nurse practitioners working in behavioral health)
5. Nurse practitioners, Certified Nurse Midwives, and Physician Assistants
6. Medical Therapists, e.g., physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
7. Licensed Genetic Counselors
8. Audiologists
9. Acupuncturists (non-MD/DO)
10. Registered Dietitians

In addition, there are several physician specialty types whose practices are primarily limited to the outpatient arena and thus are exempted from the requirement for hospital privileges. These specialties are:

1. Addiction Medicine/Addictionology
2. Allergy & Immunology
3. Dermatology
4. Genetics
5. Occupational Medicine
6. Pain Management

7. Physical Medicine & Rehabilitation (Physiatrists)
8. Psychiatry
9. Public Health and General Preventive Health
10. Rheumatology
11. Radiation Oncology practicing at a CIHQ, TJC, NIAHO- or ACHC-approved facility
12. Ophthalmology
13. Neuromusculoskeletal Medicine & Osteopathic Manipulative Medicine
14. Primary Care physicians whose patients are admitted to a participating hospital with an established hospitalist program
15. Physicians in any specialty who have been credentialed to participate solely as a Telemedicine Provider (Note: if such a physician later applies to participate as an office-based physician, the hospital privilege requirement may apply)
16. Anesthesiologists practicing in an outpatient setting
17. Radiologists practicing in an outpatient setting.
18. Pathologists practicing in an office setting
19. Nuclear Medicine physicians practicing in an outpatient
20. Developmental-Behavioral Pediatrician practicing in an outpatient setting

All other MD and DO provider types within the scope of the credentialing program, and dentists who practice as Oral-Maxillofacial Surgeons are required to have hospital privileges or appropriate admitting arrangements. This includes all PCP providers (family physicians, pediatricians, internists, & general practitioners) and Specialty Providers other than those specifically exempted by the listings above.

# Claims Submission

## Electronic Claims Submissions

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

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

Reference the Transaction Specific Companion Documents available on the EDI webpage. Go to **anthem.com/edi**. Select **Virginia** from the dropdown list and **enter**. Select **Companion Guide > Review the Guide**, then see the appropriate link under the *Section B – Transaction Specific Companion Documents* heading.

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

## Claim Submission Filing Tips

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

File Claims with dollar amounts unless Providers are submitting CPT Category II codes, which are used for tracking purposes only and carry no reimbursement value. Providers may submit Claims with $0 dollar line charges but may not submit Claims with a total Claim charge of $0.

Anthem requires all professional providers to submit all Claims using their individual 10-digit National Provider Identifier (NPI) number.

**Exceptions:** Certain provider specialties may submit Claims using their group or organizational NPI number only if designated by Anthem as "exempt billable group" based on your current agreement type:

**Professional agreement:** Anesthesiologists, Emergency Medicine physicians, Urgent Care physicians, Hospitalists, Intensivists (adult and pediatric), Neonatologists, Pathologists, and Radiologists.

**Ancillary agreement**: Acupuncture, Hearing Aid Supplier, Private Duty Nursing providers, Therapy providers (physical, speech, occupational), and Laboratories.

On professional claim form 1500, 33A is where the group NPI information should be entered.

Anthem follows the Standard Transactions and Code Sets final rule for the Administrative Simplification provision of the Health Insurance Portability and Accountability Act **(HIPAA).**

### Ambulatory Surgical Centers

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

### Ancillary Filing Guidelines

Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims.
- Ground or independently contracted ambulance Providers should file the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located. Point of drop-off zip code required.
- Air Ambulance providers contracted through a facility and submitting services on UB-04 CMS 1450 (facility claim form), should file claims to the Plan whose service area matches the facility (local Plan).
- For Professional Claims (CMS-1500 submitters), the POP (Point of Pick-up) ZIP Code should be submitted in field 23 or 54. Point of drop-off zip code required.
- Bill appropriate modifiers for HCPC-codes for appropriate combination billing.

Durable/Home Medical Equipment and Supplies

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

- Delivered to patient's home – File the Claim to the plan in the service area where the item was sent/delivered.

- Purchased at retail store – File the Claim to the plan in the service area where the retail store is located.

Home Infusion Therapy - Services and Supplies

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

Independent Clinical Laboratory Claims

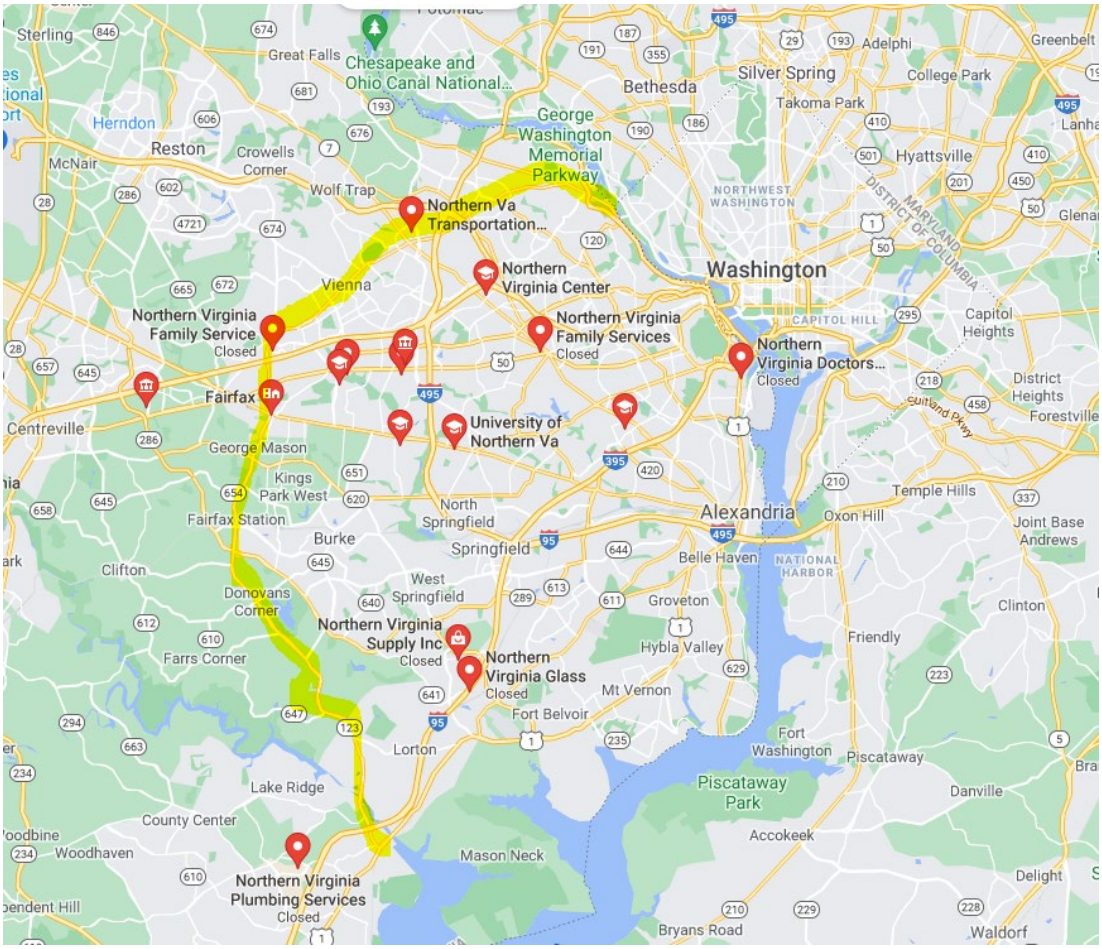
- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring provider's location (based on NPI)
- Independent lab Claims are determined by the place of service 81.
- Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to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

Medical Pharmacy Claims

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

**Note:** Claims for Members enrolled in the Blue Cross Blue Shield Service Benefit Plan, also known as FEP, are not subject to the aforementioned BCBSA mandate for ancillary Claims filing.

## BlueCard Filing Tips




*(Route 123 outlined per information in section B below)*

As a member of the national Blue Cross and Blue Shield Association's BlueCard® program, Anthem (VA) is considered the local or HOST plan. The HOME plan is the state/plan from which the Member's policy originates. For out-of-state "Blue" Claims, providers submit 837P electronic Claims to Anthem's payor number or mail to the same Anthem address above for paper Claims, with the following important **exceptions**:

A. If a Virginia (VA) provider has signed a direct contracting agreement with another "Blue" plan that is *contiguous* to VA, i.e. NC, KY, TN, WVA, MD, and sees a Member whose policy originates from that state, the VA provider must file the Claim with that Plan.

   Contiguous county claims filing rules allow claims to be filed directly to the Control/Home Plan* when all of the following criteria are met:

   - Control/Home Plan is Anthem (Anthem member only), AND
   - Provider is located in a contiguous county, AND
   - Provider is contracted with the Control/Home Plan* (product specific), AND
   - Control/Home Plan's member lives or works in the Control/Home Plan's service area, AND
   - Service is provided in the contiguous county

B. If a VA provider is located in the Northern VA/Washington, DC area, the determination of where to send the Claim is based upon three factors: the provider's agreement status with Anthem in VA and with CareFirst in DC, the Member's network (Par, PPO, etc.), and the location where treatment was rendered. This is relative to state Route 123, which is the official boundary that defines the Anthem and CareFirst Service Areas. **(See the Where to File BlueCard Claims Northern VA/DC Service Area Grid below.)**

   Anthem-contracted Providers may only charge a Member for their Cost Share at the time of service, i.e. copayment, coinsurance, deductible.

   The HOME plan is responsible for a Member's eligibility and benefits, as well as medical policy/authorizations. To verify this information pre-service, call 1-800-676-BLUE and follow the menu prompts.

   For more information about the BlueCard Program requirement for pre-service (authorizations) review, Providers and Facilities can access the BlueCard Provider Manual, online go to anthem.com, select **For Providers**, select **Policies, Guidelines & Manuals**, scroll down and select "**Download the Manual**", scroll to the Provider Manual Library section and choose BlueCard Provider Manual.

   The HOST plan (Anthem) is responsible for receiving Claims and remitting the outcome.

   To inquire about Claim status, adjustments, resubmissions and requests for additional information post-service, call 1-800-533-1120 and follow the menu prompts.

See the BlueCard® Program Overview Section below for more detail about the BlueCard® Program and links to the BlueCard® Provider Manual.

Where to file BlueCard Claims

*Anthem's Service Area:* The entire state of Virginia EXCEPT the City of Alexandria, Arlington County and Fairfax County that is east of VA Route 123 (including Fairfax City and the town of Vienna)

*CareFirst Service Area:* The District of Columbia, Montgomery and Prince George's Counties in Maryland AND the City of Alexandria, Arlington County and Fairfax County that is east of VA Route 123 (including Fairfax City and the Town of Vienna)

**Note:** For Providers in Fairfax, Fairfax Station, Lorton, McLean, Oakton, Vienna, or Woodbridge, your service area may fall in both jurisdictions.

Instructions for using this Grid:

1. First, find the Plan's Service Area (as described above) in which the Member received treatment not where the Claims/billing office is located.
2. Next, determine the Provider's contracting status for each Plan as it pertains to the specific network in which the patient has benefits (i.e. Traditional, PPO, HMO, etc.) and whether you are contracting with that network. **Select the appropriate scenario number either #1, #2 or #3 in the boxes within that Service area.**
3. Now, determine which Plan issued the patients coverage (see column header for VA, DC and "other") and follow the grid to the appropriate box to see which plan should receive Claim.
4. **Note:** These rules apply to BlueCard® Claims only. FEP Claims must be sent based solely on the location of treatment. Remote Providers (LAB, DME and Specialty Pharmacy) should follow the National BCBSA mandate referenced above

| If Office Location where patient is treated in | And, Provider Contract Status by network is | For Anthem VA cardholders, Send Claims To: | For CareFirst (DC) cardholders, Send Claims To: | For cardholders of all other Blue, Send Claims To: |
|---|---|---|---|---|
| Anthem Blue Cross and Blue Shield Service Area (West of VA Route 123) | YES w/VA #1 NO w/DC | **ANTHEM** | **ANTHEM** | **ANTHEM** |
| | YES w/VA #2 YES w/DC | **ANTHEM** | **CAREFIRST** | **ANTHEM** |
| | NO w/VA #3 YES w/DC | **ANTHEM** | **CAREFIRST** | **ANTHEM** |
| CareFirst Blue Cross Blue Shield Service Area (East of VA Route 123) | YES w/VA #1 NO w/DC | **ANTHEM** | **CAREFIRST** | **CAREFIRST** |
| | YES w/VA #2 YES w/DC | **ANTHEM** | **CAREFIRST** | **CAREFIRST** |
| | NO w/VA #3 YES w/DC | **CAREFIRST** | **CAREFIRST** | **CAREFIRST** |

FEP Claims for Providers and Facilities in Northern VA/DC Areas

Relative to the VA state Route 123 boundary but different from the BlueCard® rules, Northern VA/DC providers who see Members carrying the Federal Employee Health Benefit Program (FEHBP or FEP) ID card must send these Claims to either Anthem (VA) or CareFirst (DC) based **solely** on the Service Area in which treatment is rendered.

### CPT Coding

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

### Duplicate Claims

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

### Late Charges

Late charges for Claims previously filed can be submitted electronically. Providers and Facilities must reference the original Claim number when submitting a corrected electronic Claim. If attachments are required, submit them using the PWK attachment face sheet. (See Electronic Data Interchange website for instructions at **anthem.com/edi**).

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

### Maternity Delivery Claims

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

### National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

### Negative Charges

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

### Not Otherwise Classified (NOC) Codes

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

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

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

### Other Insurance Coverage

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

CMS-1500 Fields:

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

Including Explanation of Medicare Benefits (EOMB) or Other Payor Explanation of Benefits (EOB):

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

**Preventive Colonoscopy – Correct Coding**

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

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

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

## Claim Inquiry/Adjustment Filing Tips

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

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider receives the answer to the Claim Inquiry, the Provider may opt to begin the Claim Payment Dispute process.

  Providers can Chat with Payor or send a Secure Message through the Availity Portal. If Providers are unable to utilize the Availity portal for the inquiry, they can call the number on the back of the Member ID Card and select the Claims prompt, or by using the Claim Information/ Adjustment Request Form 151. Reference the Availity Portal section in this Manual.

- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Typically, Anthem makes the request for this information through the Explanation of Payment (EOP) The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim. To upload the requested documentation from **Availity.com**, select the Claims & Payments tab to access Claims Status. Enter the necessary information to locate the claim and use the Submit Attachments button to upload requested documentation. Additional information may be submitted by attaching any required documentation to a Claim Information/Adjustment Request Form 151.

- **Clinical / Medical Necessity Appeals**: Information about an appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational is located in the *Clinical Appeals* section within the Provider Manual.

- **Claim Payment Disputes:** Refer to the *Claim Payment Dispute* section for further details.

- **Precertification Disputes:** Precertification disputes should be handled via the process detailed in the letter received from the Utilization Management department. If Providers or Facilities disagree with a clinical decision, follow the directions detailed on the letter. A Precertification appeal can be submitted through the digital prior authorization application on **Availity.com**. Select the Patient

Registration tab to access Authorizations & Referrals. Sending precertification requests or appeals to the provider correspondence address may delay responses.

- **Corrected Claims:** Submit a corrected Claims should only information on the Claim form. Access your claim on Availity.com through the Claims & Payments tab. If the inquiry is about the way the Claim processed, refer to the prior sections. If Providers have corrections to be made to the Claim, submit them according to the Corrected Claim Guidance below.

**Proof of Timely Filing**

Claims must be submitted within the timely filing timeframe specified in the Provider Agreement. All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request.

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

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

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

Acceptable documentation includes the following:

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

   If the Provider doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.
4. If the Claim was originally filed electronically, a copy of Anthem's electronic Level 2 or the respective clearinghouse's acceptance/rejection Claims report is required; a copy can be obtained from the Provider's EDI vendor, EDI representative or clearinghouse representative. The Provider also must demonstrate that the Claim and the Member's name are on the original acceptance/rejection report. When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.
5. A copy of the Anthem letter requesting additional Claim information showing the date information was requested.

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

**Corrected Claim Guidance**

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or

additional information. To correct a Claim that was billed to Anthem in error, submit the entire Claim as a void/cancel of prior Claim. If Anthem determines the submitted claim has missing or incorrect claim information that is outlined in the filing parameters listed in the Claims Submission section above (Paper Claims Submission and Electronic Claims Submission Section), then a new claim may be needed. A written or electronic notification will be sent to the provider to notify of the data missing on submitted claim.

For Commercial network corrected claims, the resubmission of the claim can be sent for processing one (1) year from the primary's remit date. For Medicare (Medicare A and Medicare B plans) network claims where this network is primary, the resubmission of the claim can be sent fifteen (15) months from the primary's remit date.

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

| Type | Professional Claim |
|---|---|
| **EDI** | **To indicate the Claim is a replacement Claim:**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 7 |
| | **To confirm the Claim which is being replaced:**<br>• In Segment "REF – Payer Claim Control Number"<br>• Use F8 in REF)! and list the original payer Claim number is REF02 |
| | **To indicate the Claim was billed in error (Void/Cancel):**<br>• In element CLM05-3 "Claim Frequency Type Code"<br>• Use Claim Frequency Type 8 |
| | **To confirm the Claim which is being void/cancelled:**<br>• In Segment "REF – Payer Claim Control Number"<br>• Use F8 in REF)! and list the original payer Claim number is REF02 |
| **Digital** | Submit replacement, void/cancel claims through **Availity.com**<br>Select the Claims & Payments tab and click Professional Claim<br>Enter the clam information and set the billing frequency and payer control number as follows:<br>• Select Replacement of Prior Claim or Void/Cancel of Prior Claim for the Billing Frequency (or Frequency Type) field, in the Claim Information<br>• Set the Payer Control Number (ICN / DCN) (or Payer Claim Control Number) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available. |
| **Paper** | **To indicate the Claim is a replacement Claim:**<br>• In Item Number 22: "Resubmission and/or Original Reference Number"<br>• Use Claim Frequency Type 7 under "Resubmission Code" |
| | **To confirm the Claim which is being replaced:**<br>• In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim. |
| | **To indicate the Claim is a void/cancel of a prior Claim:**<br>• In Item Number 22: "Resubmission and/or Original Reference Number"<br>• Use Claim Frequency Type 8 under "Resubmission Code" |

| Type | Professional Claim |
|---|---|
| | **To confirm the Claim which is being void/cancelled:**<br>• In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim. |

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

## National Drug Codes (NDC)

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

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

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

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

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

Unit of Measurement Requirements

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

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

Location of the NDC

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


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

Correcting Omission of a Leading Zero

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

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

See the examples that follow:

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

Process for Multiple NDC numbers for Single HCPC Codes

If there is more than one NDC within the HCPCs code, Providers must submit each applicable NDC as a separate Claim line. Each drug code submitted must have a corresponding NDC on each Claim line.

If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), Providers must represent each NDC on a Claim line using the same drug code.

Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:

- KO – Single drug unit dose formulation
- KP – First drug of a multiple drug unit dose formulation
- KQ – Second or subsequent drug of a multiple drug unit dose formulation
- JW – Drug amount discarded /not administered to the patient

**How/Where to Place the NDC on a Claim Form**

837 P Reporting Fields

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

**Tips for Using NDCs When Submitting Electronic Claims**

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

Digital submission through **Availity.com**:

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

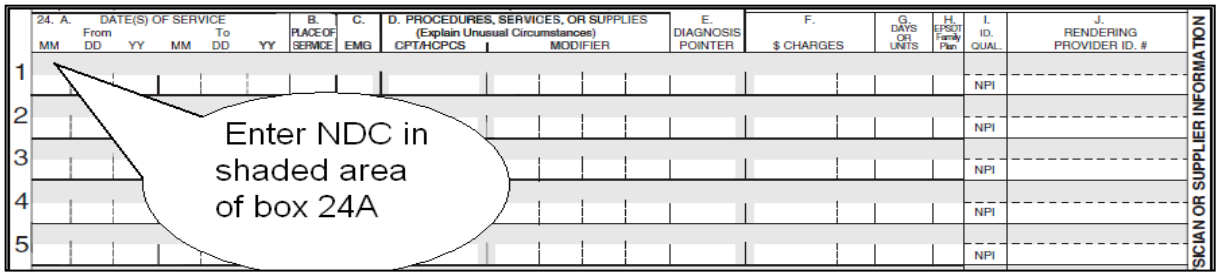
For more information about how to submit an electronic claim including the NDC Code field using Availity Essentials, log onto **Availity.com**, select the Help & Training tab, and enter Professional or Facility Claim in the search bar.

CMS 1500 Claim Form**:**

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

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

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




## Paper Claims Submissions

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

Claim failure to submit them on the most current CMS-1500 (Form 1500 (02-12) will cause Claims to be rejected and returned to the Provider. More information and the most current forms can be found at **cms.gov**.

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims.
- If Providers are submitting a multiple page Claim, the word "continued" should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid Member identification number including three-digit prefix or R+8 numeric for Federal Employee Program® (FEP®) Members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.
- Claims submitted on paper for all Anthem products except FEP (whether group or individual; whether Par, PPO, HMO, or Medicare), and for any other paper correspondence regarding Anthem Members, the mailing address is:

  **Anthem Blue Cross and Blue Shield**
  **P.O. Box 27401**
  **Richmond, VA 23279**

  Paper Claims for Medicaid can be sent to:

  **Mail stop: IN999**
  **P.O. Box 61010**
  **Virginia Beach, VA 23466**

  Paper Claims for FEP can be sent to:

  **Federal Employee Program**
  **P.O. Box 105557**
  **Atlanta, GA 30348-5557**

  Paper Claims for CareMore can be sent to:

  **CareMore Claims Department**
  **P.O. Box 366**
  **Artesia, CA 90702-0366**

**Recommended CMS Form 1500 (02-12) Claim Fields**

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

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

## Medical Records Submission

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

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

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

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

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

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

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

### Medical Records Submission with Initial Claim

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

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

When submitting medical records that are not requested by Anthem, include a clear description of the billed code submitted with the Claim to help ensure prompt processing of the Claim for all

miscellaneous, not otherwise classified (NOC), not otherwise specified (NOS), and unlisted HCPCS and CPT codes.

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

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

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

- Log in to Availity Essentials portal
- Select **Claims & Payments** > **Attachments - New**
- From the **Inbox** tab, locate the appropriate Claim
- Add files with supporting documentation

When a PWK segment is submitted with the claim, an intake with the attachment control number will display in the Attachment New inbox for seven (7) calendar days. If the document is not received within the seven (7) calendar day requirement, documentation can be uploaded using Claims Status by locating your claim and attaching the document.

**Types of Medical Records Required**

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

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

**Anthem May Request Additional Documentation**

Some situations may require medical records in addition to what was submitted with the Claim. Although these situations may not have specific rules and guidelines, Anthem will make every attempt

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

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

**Medical Record Appeals**

When a request for additional information is received in support of the resolution of a grievance or appeal, the provider should respond within ten (10) calendar days of the request, or sooner, depending upon the urgency of the matter or as required by state or federal law, statute or regulation.

**HIPAA Privacy Rule – Minimum Necessary**

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

## Electronic Data Interchange (EDI)

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

**Payer IDs**

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

**Advantages of Electronic Data Interchange (EDI)**

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

**Use Availity for the following EDI transactions**

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

How **Providers and Facilities can** efficiently **use the Availity EDI Gateway**

Availity EDI submission options:

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

**EDI Response Reports**

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

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

**Electronic Data Interchange Trading Partner**

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. An EDI 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 **www.availity.com.**

Select Login if already an Availity user, choose My providers < Transaction Enrollment or choose Register if new to Availity.

**Electronic Remittance Advice (ERA) (835)**

The 835 electronic remittance advice (ERA) eliminates the need for paper remittance reconciliation. Use Availity to register and manage ERA account changes with these three easy steps:

1. Log in to **Availity** at **availity.com**
2. Select My Providers
3. Click on Enrollment Center and select Transaction Enrollment

If a provider or facility use a clearinghouse, billing service or vendor, work with them on ERA registration.

**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 select **Virginia.** On the EDI page scroll to the bottom section EDI Resources and select the Electronic Funds Transfer tab.

**Virtual Credit Cards (VCCs)**

For Providers and Facilities who don't enroll in EFT, and in lieu of paper checks, Anthem is shifting some reimbursements to virtual credit cards (VCCs). VCCs allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply.

For detailed information, refer to the *Provider and Facility Digital Guidelines* section of this Manual.

**Use EDI to submit corrected claims**

For corrected electronic claims use one the following frequency codes:

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

EDI segments required:

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

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

**Contact Availity Essentials**

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

**Useful EDI Documentation**

- **Anthem EDI Webpage** – This webpage contains the **payer** specific companion guides and links to Availity Payer ID list.
- **Availity EDI Connection Service Startup Guide** – This guide includes information to get started with submitting Electronic Data Interchange (EDI) transactions to Availity Essentials, from registration to on-going support.

- **Availity EDI Companion Guide** – This Availity Essentials EDI Guide supplements the HIPAA TR3s and describes the Availity Essentials Health Information Network environment, interchange requirements, transaction responses, acknowledgements, and reporting for each of the supported transactions as related to Availity Essentials.
- **Availity Essentials Registration Page** – Availity Essentials registration page for users new to Availity Essentials.
- **X12 External Code Listing** – X12 code descriptions used on EDI transactions.

## Overpayments

### Refunds Due to Members

When Providers become aware of an excessive or mistaken payment received from a Member, Providers must promptly reimburse any overpayment to Member within 30 days of becoming aware of such overpayment.

### Refunds Due to Anthem

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

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

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

### Anthem Identified Overpayment (aka "Solicited")

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

- The payment coupon
- Member ID number
- Member's name
- Claim number
- Date of service

- Reason for the refund as indicated in the refund request letter

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

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

**Provider and Facility Identified Overpayments**

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

- Submit a refund check with supporting documentation outlined below, or
- Submit the Provider Overpayment Refund Form (Virginia) with supporting documentation to have Claim adjustment/recoupment done off a future remittance advice

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

- Provider Overpayment Refund Form (Virginia) (see directions below for how to access online)
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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

**How to Access the Provider Overpayment Refund Form (Virginia) online**

To download the "Provider Overpayment Refund Form" directly from **anthem.com**, Select **For Providers** from the horizontal menu. On the provider landing page, choose **Find Forms**, and then select the **Provider Overpayment Refund Form**.

**Utilize the proper address noted in the grid below to return payment:**

| Make Check Payable To: | Regular Mailing Address: | Overnight Delivery Address: |
|---|---|---|
| Anthem Blue Cross and Blue Shield | Anthem Blue Cross and Blue Shield<br>PO Box 73651<br>Cleveland, OH 44193-1177 | Anthem Lockbox 73651<br>4100 West 150th Street<br>Cleveland, Ohio 44135 |

# Medicare Crossover

### Claims Handling for Medicare Crossover

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

When a Medicare Claim has crossed over, Providers and Facilities must wait thirty (30) calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Member's Blue Plan.

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

The Claims Providers and Facilities submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately fourteen (14) days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to thirty (30) additional calendar days for Providers or Facilities to receive payment or instructions from the Blue Plan.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will

process with a consistent application of pricing, Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

**Medicare Crossover Claims FAQs**

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

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

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

   For more information, visit Anthem's website at anthem.com or contact the local Anthem Plan.

# Claim Payment Disputes

## Provider Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Anthem Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome. Providers and Facilities must complete the Claim Payment Reconsideration and Claim Payment Appeal processes set forth in this Provider Manual before they can initiate the dispute resolution and arbitration process set forth in your Provider or Facility Agreement.

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

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

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

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

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

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

Essentials section in this Manual.

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

Reference the Claims Submission Filing Tips section for additional information.

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

**Step 1: Claim Payment Reconsideration**

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

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

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

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

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

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

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

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

**Step 2: Claim Payment Appeal**

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

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

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

**Required Documentation for Claims Payment Disputes**

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

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

**How to Submit a Claim Payment Dispute**

There are several options to file a Claim Payment Dispute:

- Online through Availity Essentials (preferred method where available)
- Mail all required documentation to:

  Anthem Claim Payment Dispute
  PO Box 27401
  Richmond, VA 23279

- Call the Number on the back of the Member ID Card

# Clinical Appeals

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

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

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

**Clinical Appeals**

Clinical Appeals can be used if Providers or Facilities disagree with a clinical decisions. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/ investigative. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made through Availity.com using the Authorizations & Referrals application, where available, verbally, in writing, for appeals regarding prior authorization clinical adverse decisions.

Anthem Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to Anthem's Member Complaint and Appeal Procedures, for each applicable state. Provider Customer Service will help Providers and Facilities determine what action must be taken and if a Designation of an Authorized Representative form is needed. The Designation Of An Authorized Representative form (DOR) form can be found online at **anthem.com**. Select **For Providers**, Select **Forms and Guides** (under the Provider Resources column), if needed use the **Change/Select State** link at the top right. Scroll down and select **Forms and Guides**, then scroll down and select **Claims & Appeals** in the Category drop down and select **Designation of an Authorized Representative (DOR)**.

**Guidelines and Timeframes for Submitting Clinical Appeals**

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

- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.
- For clinical appeals, there are two (2) types of review: expedited and standard.
    - *Expedited Appeal:* Anthem offers an expedited appeal for decisions meeting the expedited criteria. Requests to handle a review as "expedited" are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member's designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Member Appeal Procedures exclusively.

      When a request for information is received in support of the resolution of a clinical appeal, the provider is required to respond within ten ~~seven~~ days of the request or sooner dependent upon the clinical urgency of the case in accordance with the state or federal law, statute, or regulation.
    - *Standard Appeal:* A standard appeal is available following the reconsideration, or initially, if it is formally requested.
- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.
- Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Detailed instructions are included in the UM decision letter.
- Appeals should be submitted to Anthem, along with:
    - A copy of the response to the original complaint.
    - Provider or facility name, address, phone number, email and either NPI or TIN
    - The member's name and Anthem ID number
    - Claim, authorization, or reference number and date of service
    - Specific reason(s) for disagreement with decision
    - All supporting statements and documentation (medical records, etc.)
    - A signed DOR (Designation of Representation) is needed if the provider is appealing on behalf of the member. No DOR is required when the provider is appealing on their own behalf.
    - Send the appeal letter to:

      Anthem Blue Cross and Blue Shield
      Grievances and Appeals
      P.O. Box 27401
      Richmond, VA 23279

**BlueCard® Members**

Appeals involving clinical decisions related to Medical Necessity, experimental/investigative and/or Utilization Management (UM) decisions involving Pre-certification/Pre-authorization are the responsibility of the Blue Plan insuring or administering benefits for non-Anthem Members (the Member's Home Plan).

Technically the Member, not the Provider or Facility, is responsible for obtaining the necessary authorization prior to the delivery of non-inpatient admission services. Providers must obtain the necessary authorization prior to the delivery of inpatient admission services. Failure to obtain the necessary authorization may result in non-payment to the provider. Anthem understands that many providers obtain Pre-certification/Pre-authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

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

# Member Quality of Care/Quality of Service Investigations

## Overview

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

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. Requests for information, including medical records, must be returned by Providers and/or Facilities on or before the due date on the request letter so that a determination can be made regarding the severity of the Potential QOC/QOS concern. Failure to return or timely return the requested information may result in escalation of the issue and

potential corrective action, up to and including, review for termination of contract and removal from the network.

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

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

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

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

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

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

## Corrective Action 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 request for information for investigations, the completion of corrective action plans by the noticed deadline and/or failure to comply with the terms of a corrective action plan will be referred to the Credentialing Committee for further actions, up to and including, termination of contract and removal from the network.

## Reporting

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

## Preventable Adverse Events (PAE) Policy

### Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

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

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

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

CMS Hospital Acquired Conditions (HAC)

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

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

**Providers and Facilities (excluding Inpatient Acute Care General Hospitals)**

Four (4) Major Surgical Never Events

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

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

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

## Medical Care Provided to or by Family Members

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

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

# Coverage and Clinical Guidelines

## Clinical Practice Guidelines

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

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

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

## Preventive Health Guidelines

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

The current guidelines are available online. To access the guidelines, go to anthem.com. Select **For Providers** and **Virginia** select **Policies, Guidelines and Manuals** from the horizontal menu under More Resources. Scroll to **Preventive Health Guidelines** and select "**Review the guidelines**."

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

## Coverage Guidelines and Clinical Utilization Management (UM) Guidelines

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

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

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

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

### Coverage Guidelines and Clinical UM Guidelines Distinction

Coverage guidelines 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, Coverage Guidelines may be developed to address experimental or investigational technologies (including a novel application of an existing technology) and services where there is a significant concern regarding Member safety. Clinical UM guidelines may be developed to address Medical Necessity criteria for technologies or services where sufficient clinical evidence exists to evaluate the clinical appropriateness of the request, goal length of stay (GLOS), place of service and level of care. In addition, Coverage Guidelines are implemented by all Anthem Plans while Clinical UM Guidelines are adopted and implemented at the local Anthem Plan or line of business discretion.

### Accessing Coverage Guidelines and Clinical UM Guidelines

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

To locate Medical Guidelines online, go to **anthem.com**. At the top of the screen, select **For Providers** under Provider Resources. Select **Policies, Guidelines & Manuals**, then select **Virginia**. Select "**View Coverage Guidelines & Clinical UM Guidelines**". Search for policies or select "Full List page" to view.

To locate Medical Policy and Clinical UM Guidelines and Prior Authorization requirements for **BlueCard** Out-of-area members, go to **anthem.com**. Select **For Providers** and then select **Virginia**,

then choose "**Prior Authorization**" under Claims in the horizontal menu. Scroll down the page to **Helpful Links** and select "**Medical Policy and Prior Authorization for Blue Plans**".
*Page link:* **Medical Policy and Prior Authorization for Blue Plans**

**Clinical UM Guidelines**

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

To view the list of specific clinical UM guidelines adopted by Virginia, navigate to the Disclaimer page by following the instructions above for Coverage Guidelines and Clinical UM Guidelines (for Local Plan Members); scroll down the page, select the link titled, "**Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield in Virginia**"

**Other Criteria**

In addition to Medical Guidelines and Clinical 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 guidelines supersede. To access this other criteria, go to **anthem.com**. Select **For Providers,** under **Provider Resources** select **Policies, Guidelines & Manuals**, then select Change/Select a State, Select **View Coverage Guidelines & Clinical UM Guidelines** and scroll to **Other Criteria** and Select the specific criteria needed.

# Utilization Management Program and Plan (the "Program")

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

## Introduction

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

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

## UM Definitions

The following terms, as used in this document, shall have the meanings shown below:

1. **Adverse Determination:** means a denial, reduction or failure to make payment (in whole or in part) for a benefit based on a determination that a benefit is experimental, investigational, or not medically necessary or appropriate as defined in the applicable health benefit plan. This may apply to Prospective, Continued Stay, and Retrospective reviews.
2. **Business Day:** Monday through Friday, excluding designated company holidays.
3. **Continued Stay Review:** (continuation of services). Utilization review that is conducted during a Member's ongoing stay in a Facility or course of treatment. Continued Stay Review includes continuation of services (Urgent Care & Extensions).
4. **Discharge Planning:** includes coordination of medical services and supplies, medical personnel and family to facilitate the Member's timely discharge to a more appropriate level of care following an inpatient admission.
5. **Notification:** The telephonic and/or written/electronic communication to the applicable Provider(s), Facility and the Member documenting the UM determination.
6. **Pre-certification** (includes Pre-authorization, Pre-service, Prospective): List of services that require Review by UM prior to service delivery. For UM team to perform Reviews, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.

**Review Types**

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

## Program Overview

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

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

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

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

UM review timeframes follow Federal, State and accreditation requirements as applicable to the review.

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

- The information submitted with the Claim, or on the medical record, differs from that given for the pre-Claim UM review.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

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

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

The list of Pre-certification requirements can be accessed online. Go to anthem.com and select **For Providers**. Under the **Claims** heading, select **Prior Authorization**. Select **Virginia** if needed. Select the appropriate link depending on the type of Member Plan. The Pre-certification requirements may be confirmed by contacting the appropriate phone number on the back of the Member's ID card.

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

### Electronic Data Exchange

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

## Prospective Review and Continued Stay Review

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

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

Provider and Facility must request an inpatient review for non-emergency direct inpatient transfers made from one hospital to another. If the transfer is approved, the Program will reimburse for ambulance transfer services.

Coverage for services for an HMO Member may be denied for failure to obtain a Pre-certification Review, except in the case of an Emergency. Coverage of services for a non-HMO Member may result in a partial or full denial of coverage if in retrospect, the service provided is determined not to be Medically Necessary. Sufficient clinical information must be provided to make a determination on whether a requested service is Medically Necessary.

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

## Coverage Guidelines and Clinical UM Guidelines

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

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

**On-site/Electronic Medical Record Review (EMR)**

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

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

**Observation Bed Policy**

Refer to the “Observation Services Policy” located in the Reimbursement Policies section of **Anthem.com**.

**Retrospective Utilization Management**

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

**Failure to Comply with Utilization Management Program**

If non-emergency inpatient admissions and outpatient procedures that require an Admission, Health Service or Pre-certification Review as specified by Anthem are not submitted for review within the time frames required in **Prospective and Continued Stay Review section**.

Provider will be subject to a one-hundred percent (100%) penalty on amounts payable under the Agreement (i.e. no payment shall be made).

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

Members may not be balance billed for penalty amounts.

**Extenuating Circumstances Approval List**

- Insurance information was not available from the Member at the time of admission or incorrect information was received from the Member, due to illness, mental status, or language differences at the time of services. Including primary payer issues (e.g., Medicare, aka admissions or VIP member admitted under a false name, etc.).
- Anthem health system problems prevented authorization from being obtained or Anthem health provides erroneous information, (e.g., misinformation about authorization requirements or Member eligibility).
- Admission or services received are court ordered.
- The need for another covered service was revealed and performed at the time the original authorized service was performed, the newly revealed covered service would not receive a late call penalty
- The Member presented with emergency/urgent condition or life-threatening illness/injury/trauma (e.g., intubation or loss of consciousness).
- Routine maternity admissions/newborn admissions – active/Coordination of Benefits membership
- Routine maternity admissions
- Proof of timely notification of admission of emergency admission was received with forty-eight (48) hours or the first business day following admission. If the forty-eight (48) hours expires on a day that is not a business day the timeframe will be extended to include the next business day. Substantiation may be requested.
- Provider or Facility was given misinformation about authorization or patient eligibility by an Anthem Health employee or Department of Medical Assistance (DMAS).
- Transition of Care. This includes transfer from one hospital to another or transfer to home.
- The Member was traveling out of the area and the Provider or Facility had difficulty finding who to call for the authorization.
- Retro enrollments issues where the member was terminated and then reinstated, but the application was not loaded timely.
- Member's plan reinstated post admission and retroactive to a date prior to the admission.
- A Provider or Facility system outage extending forty-eight (48) hours beyond the date of service requiring authorization prevented the authorization from being obtained and Provider or Facility has provided adequate evidence of the system outage.

- A Member is admitted to observation and then becomes inpatient.
- Any other Extenuating Circumstances specific to the health plan.

**Utilization Statistics Information**

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

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

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

**Submit Pre-certification Requests Digitally**

Using the Availity multi-payer Authorization application for submitting pre-certifications offers a streamlined and efficient experience for providers requesting inpatient and outpatient medical services for members covered by Anthem plans. Providers can also use the Availity Authorization application to check authorization status, regardless of how the authorization was submitted. To submit digital pre-certifications, log onto Availity.com and select the Patient Registration tab to access Authorizations and Referrals then select Authorization Request.

**Peer to Peer Review Process**

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

**Quality of Care Incident**

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

**Audits/Records Requests**

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

## Case Management

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

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

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

## Behavioral Health Utilization Management

Health Benefit Plans do not require a Health Services Review for outpatient psychiatric therapeutic procedures (CPT 90801-90899, 96101-96119, and appropriate E&M codes), but may require Health Services Review for Intensive In-Home (IIH) Services (HCPCS H0023), Transcranial Magnetic Stimulation (TMS) (CPT 90867-90869) and Applied Behavior Analysis (ABA) (CPT 97151-97158, 0362T and 0373T).

A. The Attending Provider shall obtain a Health Services Review for any IIH, TMS or ABA services. Health Services Review can be obtained during normal Program business hours.

B. IIH, TMS or ABA Health Services Review requests will not be reviewed retrospectively for more than sixty (60) days after the service is rendered, except in cases of Emergency services. If a Health Services Review is not obtained within sixty (60) days after a non-emergent TMS or ABA service is rendered, then, notwithstanding any provision to the contrary contained herein or in any Provider agreement, Anthem and Members are not responsible for making any payment to the Attending Provider.

C. The initial Health Services Review decision will cover a specified number of IIH, TMS or ABA sessions. Any additional services must be certified, and a treatment plan must be sent to the Program's behavioral health department prior to services being rendered.

The Program uses behavioral health clinical guidelines and coverage guidelines for the purpose of determining benefit coverage and assisting behavioral health care professionals in understanding the basis of Anthem's level of care and continuation of care decisions. The clinical guidelines are primarily symptom and behavior-based and were developed with input from behavioral health care practitioners, including practitioners at academic institutions. The criteria are reviewed at least annually. The behavioral health medical directors lead this annual review process and are responsible for synthesizing input from the various sources, including relevant scientific literature and a consideration for other published criteria sets, and making appropriate revisions to the criteria. A number of persons, both internal and external to Anthem, are asked to review the criteria annually, including Anthem's behavioral health case management staff, behavioral health psychiatric consultants, and a sample of network Providers, including Providers specializing in treatment of children, adolescents, adults, substance use disorder and dependency. The criteria are also reviewed annually by Anthem's Medical Policy & Technology Assessment Committee (MPATC). The latest version of the behavioral health clinical guidelines is made available to Providers and Members at

their request by calling Medical Management at the number on the Member's ID card and available at anthem.com > select **For Provider** > select **Policies, Guidelines & Manuals** > select **Virginia** > select **View Coverage Guidelines & Clinical UM Guidelines**.

## Audit Activities

A. Under the Program, the Provider agree to allow on-site reviews by the Program review staff to examine the medical records, review forms and/or itemized bills related to Claims under the Program. The Program reserves the right to make benefit determinations based on these reviews and retract or recover any reimbursement made based on falsified, misleading or incomplete information. The method of review and selection of cases will be determined by the Program.

B. Periodically the Program will perform retrospective audits of cases receiving inpatient or outpatient care, medical equipment supplier services or private duty nursing services. While the focus of each audit differs, the combined purposes of these audits are to confirm documented Medical Necessity of care received, relevance of pre-procedure diagnostic testing, if any, validation of the appropriate setting and/or use, quality of care and accuracy in coding and billing for services received. These reviews are conducted on Health Services Reviews, inpatient admissions or outpatient services (Retrospective Audits); outpatient surgical services received in ambulatory surgery or free-standing ambulatory surgery centers (Ambulatory Surgery Audits); or Provider bills (Bill Audits).

## Audits/Records Requests

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

## Program Responsibilities

The Program may give consideration, (to the extent that, and for as long as, Anthem deems appropriate) to nationally recognized, consensus-based and/or published medical literature and guidelines or to criteria that are based on these (or to any portion thereof) when making Medical Necessity and other coverage determinations, Examples of such guidelines and/or literature that may be utilized or considered, in whole or in part, include, without limitation, MCG Care Guidelines * Guidelines, Anthem coverage or clinical guidelines, and/or literature (or any portion thereof) developed by other national or specialty organizations may also be utilized and/or given consideration (to the extent that, and for as long as, Anthem deems appropriate). All utilization review standards and criteria used by the Program are objective, clinically valid and compatible with established principles of health care. They are also sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

Information about any guidelines and/or literature currently being used by Anthem can be obtained by calling the Program.

*MCG Care Guidelines are a set of optimal clinical practice benchmarks for treating uncomplicated patients with common conditions. To obtain information about MCG or to obtain a copy of the Guidelines, visit its website at **mcg.com/care-guidelines/care-guidelines** or call 1-888-464-4746. Due to licensing restrictions, the Program is unable to release entire volumes of the criteria. A copy of

the specific section of the guideline used in making an Adverse Decision only may be obtained by contacting the Program. MCG Care Guidelines are updated on an annual basis.

A. The Program arranges the services of physician consultants who are board certified specialists in all major specialty categories of health care on an “as needed” basis in conducting utilization review.

B. Review staff includes licensed registered nurses, licensed clinical social workers, licensed professional counselors, or clinical nurse specialists with at least 3 years of clinical experience who conduct the first level review under the direction of the medical director. The medical director and physician consultants have current unrestricted licenses to practice medicine in the Commonwealth of Virginia. In addition, the physician staff members have unencumbered DEA licenses, evidence of Board certification and malpractice coverage if in active practice.

C. All Medical Necessity Adverse Determinations are made in the first instance by a medical director, physician consultant or for behavioral health, a doctoral-level clinical psychologist or certified addiction medicine specialist. The Program will make a good faith attempt to obtain information from the Provider prior to rendering an Adverse Decision. If an Admission Review or Health Services Review is questioned on the basis of Medical Necessity, at any time before the Program renders a decision, the Provider is entitled to review the issue of Medical Necessity with a physician consultant or peer of the Provider who represents the Program.

D. If the Program approves an Admission Review or Health Services Review as Medically Necessary, a length of stay or number of units with time frame will be certified. Instructions on the method for Continued Stay Review - whether onsite or telephonic – and for obtaining continued Health Services Review will be provided when the original request is certified. A certification number is generated on each initial review and is a reference number only and not a confirmation that the service is approved.

E. The Program will communicate its utilization review decision to the Provider no later than two Business Days after receipt by the Program of all information necessary to complete the review and will follow up in writing within two Business Days of the decision.* As used herein, an “Adverse Decision” means a decision by the Program that a health care service rendered or proposed to be rendered was or is not Medically Necessary or is Investigational. The Notification will include instructions on how the Provider, on behalf of the Member, may seek a reconsideration of the Adverse Decision, including the name, address, and telephone number of a contact at the Program. To request reconsideration, the Provider must submit it by telephone to the contact information on the Member’s ID card.

   *** The two-day time frame applies to fully insured managed care health insurance plans. It is not applicable to self-funded health plans.**

## Reconsiderations of Adverse Determinations

Providers shall have the right to a reconsideration of an Adverse Determination. Only one reconsideration is allowed per Adverse Determination; however, the Provider still has the right to appeal. Any such reconsideration shall be subject to the following rules/requirements:

A. Reconsiderations shall be performed by an Anthem medical director or physician consultant, or a peer of the treating Provider other than the Anthem medical director or clinical peer that made the initial Adverse Determination.

B. Reconsiderations may be requested via either telephone or facsimile by a Provider.

C. The Provider must request a Reconsideration within 10 Business Days after the issuance of the initial Adverse Determination and prior to an appeal. Reconsiderations requested after 10 Business Days for the same service and the same date of service will be directed to follow the appeals process.

D. Reconsiderations are available for requests that are determined to be not Medically Necessary or Investigational. They are not available for services that are deemed to be non-covered per the contract; however, the Provider has the right to appeal contractual denials. See the Clinical Appeals section for information on requesting an appeal.

E. The Program shall notify the Provider verbally at the time of the reconsideration determination, and in writing following the reconsideration determination. If the reconsideration decision is upheld the Program will include the criteria used and the clinical reason for the Adverse Decision. In addition, the Provider will be informed of the process for filling an appeal with the contact's name, address, and telephone number.

F. Any reconsideration shall be rendered, and the decision provided to the Provider and the Member in writing within 10 working days of receipt of the request for reconsideration. Expedited reconsiderations are not available.

G. If the Provider requests that the Adverse Determination be reviewed by a peer of the Provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal. In such cases, the Member shall be notified that the reconsideration has been vacated and an appeal initiated, and that all documentation provided during the reconsideration process shall be converted to the appeal, and no additional action is required by the Provider.

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

## Attachment A

### Patient Medical Record Documentation Standards

The medical record is a written account of all significant clinical information pertaining to a patient. It is a critical tool for continuity and coordination of patient care over time.

Sufficient documentation in the medical record is required to enable Utilization Review staff to determine Medical Necessity, quality of care and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.

Documentation must be legible and signed by the person providing the service. Legible documentation is required to substantiate reimbursement for services. Anthem reserves the right to retract or recover any payments made when there is absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of applicable law. The CPT and diagnosis codes reported on the health insurance claim form should reflect the documentation in the medical record.

**Documentation Guidelines:**

- Each patient has an individual confidential medical record.
- Each page contains patient ID.
- Provider is identified on each entry.
- Medical record is legible.

- All entries are dated.
- Medical records are readily accessible during normal office hours.
- Specific allergies or drug reactions are documented prominently on the medical record.
- Documentation must reflect who rendered what service, why, when and to whom.
- A progress note is generated and documented after each patient contacted.

**Provider Office Documentation Guidelines**

For each patient medical record there is documentation of the following:

- Pertinent history and physical examination
- Appropriate health guidance/ counseling when indicated
- Personal and biographical data
- Physician review of consultant, lab and imaging studies
- Current medications and therapies
- Follow-up plan and/or return visit
- Completed problem list inclusive of recurrent or chronic illnesses or diseases
- Written reports for diagnostic and therapeutic ancillary services
- Completed immunization records for children below age 16
- Consultations with or referrals to other physicians and/or other Providers
- Periodic screening appropriate to patient age and conditions
- Concerns from previous visits are addressed
- For each visit there is documentation of the following:
- Reason for visit and chief complaint
- Working diagnosis
- Treatment plan, including prescribed medications
- Patient education

**Facility Documentation Guidelines**

Patients receiving services in a hospital setting must be under the medical supervision of a physician. The physician maintains responsibility for total care of the patient. Signatures and credentials are required documentation. Although members of other disciplines write notes, the Provider has the responsibility of documenting the Medical Necessity for the prescribed care.

A. All hospital services rendered must be appropriately documented in the patient's medical record. The medical record should be complete, legible and signed by the person providing the service. To be deemed complete, documentation of inpatient services must:
    - Describe the patient's clinical signs and symptoms (including specific examples) that necessitate admission including failed response to outpatient management.
    - Document an accurate and complete chronological picture of the patient's clinical course with accessibility to past and present diagnoses, and relevant health risk factors.

- Support the intensity of the patient's evaluation and/or treatment, including Provider's thought processes and the complexity of medical decision-making.
- Document the implementation of a treatment and discharge plan specifically designed for the patient, detailing frequency and type of treatment/medication and dosage; any referrals/consultations, and patient/family education follow up needs.
- Document patient's progress, including response to treatment, change in treatment, change in diagnosis/condition, and Patient's non-compliance (if relevant).
- Document continuous skilled observation and intervention by trained personnel consultants.
- Document reasons for and results of x-rays, lab tests, invasive procedures, and other ancillary services.
- Document extenuating circumstances that necessitate short periods (less than 3 hours) of absence from the Hospital (i.e., court appearance, medical/surgical treatment).

All entries to the medical records should be dated and authenticated.

All professional Provider services must adhere to the following guidelines:

- Documentation in the medical record must verify each individual charge submitted to Anthem.
- Documentation must specify date of service, time of service, type of service rendered, and the name and title of the health care professional who rendered the service. "Summary" notes, regardless of time periods summarized, will not be acceptable as verification of individual therapies or services provided.
- The CPT/diagnosis codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

Discharge Planning should begin at the time of admission. The initial assessment and other intervention should be documented in the medical record.

## Attachment B

### Behavioral Health Documentation Standards

Patients within a hospital setting must be under the medical supervision of a physician. The Attending Provider maintains responsibility for the total care of the patient. Evaluations, assessments, and other services shall be made by credentialed and/or licensed professional staff according to hospital policy and professional standards. Although members of other disciplines write psychotherapy notes, the physician of record is responsible for documenting the Medical Necessity for the prescribed psychotherapy and the total treatment program.

Signatures and credentials are required documentation for the Attending or treating Provider all licensed staff.

Sufficient documentation in the medical record is required to enable Utilization Review staff to determine Medical Necessity, quality of care and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.

Documentation must be legible and signed by the person providing the service. Legible documentation is required to substantiate reimbursement for services. Anthem reserves the right to retract or recover any payments made when there is absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of

applicable law. The determination of reimbursement requires adequate documentation of patient acuity and services provided. The Provider must maintain adequate and accurate clinical records.

**Inpatient Documentation Guidelines**

A. Admission Note

Within 24 hours of a patient's admission, the Attending Provider and the nurse performing the initial assessments must personally document their findings in the medical record. Documentation must include the time the assessment was performed by the Attending Provider.

1. Documentation of the severity of the presenting problem must support the Medical Necessity of admission for inpatient hospitalization. All DSM V diagnosis must be documented by the physician and must be consistent with the presenting problem.
2. The patient's potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the following:
   - Presenting thoughts
   - Intent
   - Plan
   - Method
3. An initial diagnostic evaluation must be documented and include the following:
   - Date of exam
   - Medical history, including medications & allergies
   - Diagnosis
   - History of alcohol and drug use
   - History of present illness
   - Social history /family history
   - Mental status exam
   - Previous treatment and outcome
   - Presenting problem – supporting signs and symptom
4. Initial treatment plan must be documented, providing the following information:
   - Goals for hospitalization
   - Estimated Length of Stay (LOS)
   - Initial Discharge Plan

B. History And Physical

Within 24 hours of admission, a history and physical (H&P) must be completed by a licensed physician and documented in the medical record. The H&P must evaluate the patient's physical and medical stability for treatment in an inpatient setting. An explanation of exceptions for any H&P component must be documented.

1. H&P documentation is to include an evaluation of the following:
   - General appearance and nutritional status

- Skin and lymph
- Head and neck
- Eyes/vision
- Ears/hearing
- Nose, mouth and throat
- Breast
- Neurological, including:
- Motor
    - Sensory
    - Cranial nerves
    - Deep tendon reflexes
    - Strength
    - Cerebrum
    - Posture, gait

  Chest and lungs
- Heart
- Abdomen
- Genitalia
- Rectal
- Bones, joints and muscles
- Clinical impression including activity level

2. Laboratory results must be documented in a timely manner.

C. Consultation Services

1. A consultation is the rendering of an expert opinion, in relation to the diagnosis or treatment of an illness or injury by a Provider other than the Attending Provider. The Provider must be qualified by training and experience to render an expert opinion in a given specialty.
2. The Attending Provider must order the consultation, and the Provider who renders it must include a written report in the medical record.
3. All consultations must be performed by the Provider billing for the service. Health Benefit Plans do not provide benefits for telephone consultations.

D. Master Treatment Plan

1. A master treatment plan that addresses measurable goals and objectives relating to the presenting problems and defines realistic goals for discharge must be documented in the medical record within 3 days
    a. All therapies and disciplines involved must be addressed in the master treatment plan.
        i. The patient's strengths and weaknesses and the ability to reach realistic goals must also be documented.

ii. The master treatment plan must be current and updated at least every 7 days.

b. Discharge Planning must be documented in the master treatment plan.

c. Specific follow up plans for post discharge must be documented.

2. Psychological testing required for differential diagnosis and the development of a master treatment plan should be ordered within 3 days of admission and results documented in the medical record within 3 days of completed testing.

E. Progress Notes

1. Documentation in the patient's progress notes is required to address the patient's response to treatment. After significant patient contact, all disciplines must record their assessment in the medical record. All entries must be dated and signed by each professional, noting their credentials.
   - Interventions, goals of the master treatment plan and coordination of services must be substantiated.
   - An explanation of positive or negative change in the patient's condition is required.
   - Deterioration or complication following initiation or change of medication must be documented.
   - Ongoing documentation of the patient's mental, functional and medical stress is required.
   - Patient's response to treatment must be documented
   - A record of the use of any physical and/or chemical restraints or seclusion must be documented.
2. The medical record must reflect daily medical and nursing documentation of the severity of illness and intensity of services rendered, and a daily progress note documented by the psychiatrist.

F. Psychotherapy

1. Documentation, written or dictated by the Provider, of psychotherapy sessions is required in the medical record to determine that the services were rendered and Medically Necessary.
2. The Provider must personally render all psychotherapy billed to the Anthem. It is recognized that there are useful milieu therapy groups run by other personnel, but these milieu therapy groups are included in the hospital charge and will not be reimbursed separately by the Anthem.
   a. Patient interactions of less than 16 minutes in duration may be documented as medication evaluation but may not be documented as psychotherapy sessions.
   b. For utilization review purposes and to qualify for reimbursement, one note for each psychotherapy session is required. The psychotherapy note must indicate the following information:
      - Date of service
      - Length of session
      - Statement of therapeutic focus, including the therapist's intervention(s)
      - Periodic reference to the patient's progress

- Individuals present at the session
- A separate note must be written in the hospital record for each patient in group therapy, indicating the nature of the participation at each session

**Behavioral Health Outpatient Documentation Guidelines**

A clinical record is required for all office psychotherapeutic services. Sufficient documentation is required to determine Medical Necessity, quality of care, appropriateness of treatment and to verify service performed for the purpose of determining coverage and reimbursement. The Provider must personally render all psychotherapy billed to the Anthem.

A. Clinical Evaluation
    1. A clinical evaluation must be documented in the medical record:
        a. The presenting problem:
            - history of present illness
            - evidence of personal distress
            - impairment of functioning

B. Medical history including medication and allergy history; current medications prescribed with dosages noted

C. Previous treatment and outcome

D. Social history/family history

E. History of alcohol and drug use

F. Mental status exam

G. Appropriate diagnosis

H. The treatment plan with goals of treatment including the estimated number of treatment sessions to achieve goals

I. Psychotherapy Notes
    1. Patient interactions of less than 16 minutes in duration may be documented as medication evaluation but may not be documented as psychotherapy sessions.
    2. Clinical notes must be documented in a timely manner and include:
        - Patient's name
        - Date of service
        - Type and length of session
        - Individuals present at the session
        - Current symptoms
        - Current level of functioning
        - Focus of session, including the therapist's intervention(s)
        - Future directions including revisions in goals, if indicated
        - Next scheduled appointment
        - Summary of treatment outcome upon termination

- A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
- Signature and credentials of treating Provider after each session, including progress toward the individual's goals

## Attachment C

### Guidelines for Skilled Nursing Care in the Home Setting

Skilled nursing and skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

A. Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists and speech pathologists or audiologists; and

B. Due to the likelihood of change in an individual's condition, requires skilled nursing personnel to observe and assess the individual in order to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures, until the treatment regimen is essentially stabilized; and

C. Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result; and

D. Are not custodial in nature or solely for convenience. Custodial care is defined as:

1. Custodial care is that care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.
2. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.
3. Custodial care essentially is personal care that does not require the continuing attention or supervision of trained, licensed medical or paramedical personnel.
4. Custodial care is maintenance care provided by family members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of physical or mental function.
5. In determining whether an individual is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

Skilled nursing care in the home setting is provided on a part-time or intermittent basis as an alternative to an initial or repeated hospitalization. It requires an order from the treating physician with documentation of a specific plan of care, the skills of a professional health care provider such as a registered nurse or a licensed practical nurse and is not custodial in nature.

These services are only covered when the patient's condition generally confines him/her to home except for brief absences. An individual does not have to be bedridden, but leaving the home does require a considerable and taxing effort.

**The following are acceptable examples of situations that generally confine the patient to home. This list is not all-inclusive:**

- Cerebrovascular accident (CVA) with severe hemiparesis.
- Severe chronic obstructive pulmonary disease (COPD) with shortness of breath (SOB) limiting ambulation.
- Unsteady gait – becomes SOB with ambulation of 10 feet or more. Requires walker and assistance of one person.
- Increased weakness, pain and stiffness due to post-operative problems.

The following are examples of situations that generally confine the patient to home but which do not qualify the patient as being "homebound." This list is not all inclusive:

- Low endurance.
- Speech impairment.
- Hearing impairment.
- Inability to drive.

Appropriate documentation of the patient's condition must be provided to help in determining whether a patient is generally confined to home.

Nursing assessment and care of a homebound patient is considered skilled when the complexity of the patient or medical treatment requires a licensed nurse to accurately assess and report findings to a physician for intervention.

<u>Examples of skilled nursing care include the following:</u>

- Parenteral medications and IV fluids received on a regular/continuous basis.
- Intravenous and enteral hyperalimentation.
- Extensive sterile dressing changes.
- Family instruction in assuming daily care for:
- Enteral feedings – once feedings have been established and tolerated, nasogastric and gastrostomy feedings are no longer considered skilled.
- Initial evaluation and teaching for home oxygen therapy.
- Teaching for use of accucheck/glucometer.
- ET suctioning when suctioning is frequent.

<u>Services NOT CONSIDERED to be examples of skilled nursing include but are not restricted to, the following:</u>

- Checking of vital signs.
- Administration of routine oral or topical medications.
- Maintenance colostomy or ileostomy care.
- Routine catheter care.
- Use of local heat for symptomatic treatment
- Non-sterile dressing changes.

- Prophylactic and palliative skin care.
- General methods of treating incontinence.
- General care of a plaster cast, braces or a prosthetic appliance.
- Assistance with Activities of Daily Living (ADL).
- Socio-economic factors do not determine whether care is skilled.
- Homemaker services
- Custodial Care

# Carelon Medical Benefits Management

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

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

## Pre-certification requests to Carelon Medical Benefits Management

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

- Access the provider portal at **providerportal.com**. Online access is available 24/7 to process orders in real-time and is the fastest and most convenient way to request authorization.
- Call the Carelon Medical Benefits Management Contact Center toll-free number **800-554-0580**.

## OptiNet Registration

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

To access the OptiNet Registration:

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

- Complete requested information.

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

For technical questions, contact Web Support at **800-252-2021**. For specific OptiNet customer services requests, contact **877-202-6543**. For any other questions, contact Anthem Provider Services.

# Quality Improvement Program

## Quality Improvement Program Overview

The Quality Improvement Program Description (QIPD) defines the quality infrastructure that supports Anthem's QI strategies. The QIPD establishes QI program governance, scope, goals, objectives, structure and responsibilities encompassing the quality of medical and behavioral healthcare and services accessible to Members.

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 strategy, Anthem uses digital-first solutions to support provision 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 care 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.

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 Anthem's medical and behavioral health programs and activities toward established goals and objectives.

### 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 and 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 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.

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

**Quality and Safety of Clinical Care**

- **Health and Wellness**: MyHealth Advantage is a proactive program that translates a Member's health information into personal guidance to help improve the safety, quality and coordination of their healthcare. This program provides personalized, actionable messaging to Members and their Providers on ways they can improve their health; optimize healthcare spending; avoid critical health issues.
- **MyHealth Coach** program offers end-to-end (enroll, engage and manage) professional one-on-one guidance from an experienced health coach. Each health coach provides education, resources, tools and support to help Members make wise informed decisions about their healthcare. Members are helped to navigate the healthcare system, comply with prescribed treatment plans and use health benefits more appropriately. The health coach serves as a central point of contact for Members who have questions or concerns about a healthcare topic or condition.

**Patient Safety for Members**

Anthem's mission is improving lives and communities, and the quality framework supports this with the promotion of continuous improvement in patient safety. The patient safety goals are to build a safer, more equitable health system and decrease the occurrence of patient safety events by creating a safety culture that improves the delivery of healthcare, health outcomes and alignment with national patient safety efforts. This will be accomplished through the promotion of safe clinical practices in aspects of clinical care and service; to engage Members and medical and behavioral health Providers concerning patient safety in aspects of patient interaction; and to identify opportunities for system and

process improvements that promote patient safety within individual practices and across the healthcare continuum. Areas for monitoring are selected by analyzing patient safety data for Members inherent to quality of medical and behavioral healthcare delivery and service. Areas of focus include Population Health Management programs that target keeping members healthy, managing members with emerging risk, patient safety or outcomes across setting and managing multiple chronic illnesses.

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

## Member Rights and Responsibilities

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

## Continuity and Coordination of Care

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

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

## Continuity of Care/Transition of Care Program

This program is for Members when their Provider terminates from the network who have been participating in active treatment with a provider not within Anthem's network.

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

Anthem will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Members, or their covered dependents with qualifying conditions, as applicable and in accordance with contractual, regulatory, and accreditation requirements, need assistance in transitioning to in-network Providers. 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, and/or when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider.

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

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

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 health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes ninety-six (96)* measures across six (6)* domains:

- Effectiveness of Care
- Access/Availability of Care
- Experience of Care
- Utilization and Risk Adjusted Utilization

- Health Plan Descriptive Information,
- Measures Reported using Electronic Clinical Data Systems

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

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

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

## Overview of CAHPS®

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

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

Results of these surveys are shared with Providers annually so they have an opportunity to learn how Anthem Members feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one.

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

## Medical Record Standards

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem has medical record standards that require Providers to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes. Medical records should be maintained in accordance with applicable laws and regulations, including 12VAC5-410-1260.

# Culturally & Linguistically Appropriate Services

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

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

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

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

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

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

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

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

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

# Centers of Medical Excellence

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

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

designations include the following transplants: adult and pediatric autologous/allogeneic bone marrow/stem cell, adult and pediatric heart, adult and pediatric lung, adult combination heart/lung, adult and pediatric liver, adult and pediatric kidney, adult simultaneous kidney/pancreas and adult pancreas.

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

**Transplant**

- Blue Distinction Centers for Transplant™ (BDCT) launched in 2006.
- Nearly 104,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of December 2022. In the United States, more than 42,800 organ transplants in 2022. In 2022, annual records were set for total number of kidney, liver, heart and lung transplants.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR), and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant programs. When BDCT and Anthem CME are combined, Members have access to over 800 transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver kidney, pancreas, and combined kidney/pancreas transplant.

**Cardiac Care**

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 30.3 million, and the percent of adults with diagnosed heart disease is 12.1%. Heart Disease is the number one (1) cause of death in the United States. The American Heart Association projects the number of Americans with cardiovascular disease to rise to 131.2 million by 2035.

- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ (BDC+) are also 21 percent more cost-efficient than non-BDC+ designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care focuses elective cardiac procedures, including cardiac valve surgery, coronary artery bypass graft (CABG), and angioplasty (percutaneous coronary intervention (PCI) while providing a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery.

**Bariatric Surgery**

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

**Cancer Care**

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

**Spine Surgery**

- Blue Distinction Centers for Spine Surgery® launched in November 2009.

- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available for Providers to work with Members, to guide them toward the most appropriate recommendation for their situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- 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.
- Recent updates to the program address the goal of reducing racial disparities in maternal health and maternal health crisis in the United States. Criteria included recommendations from organizations to enhance outcomes and reduce adverse events. Organizations included the Department of Health and Human Services (HHS), American College of Obstetricians and Gynecologists (ACOG), Alliance for Innovation on Maternal Health (AIM), and the California Maternal Quality Care Collaborative (CMQCC).
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01), Cesarean Section (PC-02) and selected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). As well as additional measures to support safe practices in childbirth, prenatal and postpartum care.

**Substance Use Treatment and Recovery**

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

**Ventricular Assist Devices**

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

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

- The U.S. Food & Drug Administration (FDA) continues to approve new cellular immunotherapy products called Chimeric Antigen Receptor T-cell (CAR-T), which are genetically modified autologous T cell immunotherapies that provides new treatment options for cancer patients. This treatment involves genetic re-engineering of a patient's white blood cells.
- There are seven (7) Chimeric Antigen Receptor T cell therapies (CAR-T) products, listed below, approved by the FDA. This list continues to grow as new products are approved:
    1. Yescarta® (axicabtagene ciloleucel) for treatment in Adult Patients
    2. Kymriah® (tisangenlecleucel) for treatment in Pediatric and Adult Patients
    3. Tecartus™ (brexucabtagene autoleucel) for treatment in Adult Patients
    4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
    5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
    6. Carvykti® (ciltacabtagene autoleucel) for treatment in Adult Patients
    7. Omisirge (omidubicel) for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.

- Anthem has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by our Bone Marrow National Transplant Quality Review Committee. Currently we have eight (8) contracted CAR-T CME Providers. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.
- The Blue Cross Blue Shield Association also has a designation, but not a contract requirement for CAR-T Providers in 2020. Providers must be certified by a product manufacturer certification program to deliver CAR-T therapy.

**Gene Therapy**

- The U.S. Food & Drug Administration (FDA) continues to approve new gene therapy products which provide new treatments for various conditions. This treatment involves Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material.

# Audit and Review

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

## Anthem Audit and Review Policy

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

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

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

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

**Definition**

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

- **Agreement** means the written contract between Anthem and Provider that describes the duties and obligations of Anthem and the Provider, and which contains the terms and conditions upon which Anthem will reimburse Provider for Health Services rendered by Provider to Member(s).
- **Audit Appeal** means a written request with supporting documentation to Anthem from a Provider or Facility to reconsider a payment determination.

- **Audit Appeal Response** means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider.
- **Audit** means post payment evaluation of Health Services or documents relating to such Health Services rendered by Provider and conducted for the purpose of determining if appropriate reimbursement under the terms of the Agreement.
- **Business Associate or designee** means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem.
- **Notice of Overpayment** means a document that constitutes notice to the Provider that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Notice of Overpayment shall contain administrative data relating to the amount of overpayment. Unless otherwise stated in the Agreement between the Provider and Anthem, Notice of Overpayment shall be sent to Provider.
- **Provider** means an entity with which Anthem has a written Agreement.
- **Provider Manual** means the proprietary Anthem document available to the Provider, which outlines Reimbursement Requirements and Policies.
- **Recoupment** means the recovery of an amount paid to Provider which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider and Anthem. In accordance with applicable laws, regulations and unless an agreement expressly states otherwise, a Recoupment may be performed against a separate Anthem payment unrelated to the service or subject made to the Provider.
- **Supporting Documentation** means the written material contained in a Member's medical records or other Provider documentation, Claim details, prior authorization clinical information, and supply invoices supporting the Provider's Claim.

**Documents Reviewed During an Audit or Review**

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

A. Confirm that health services were delivered by the Provider or Facility

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

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

   Auditors/Reviewers may review Supporting Documentation including the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

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

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

**Policy**

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

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

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

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

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

**Procedure**

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

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

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

  When conducting credit balance reviews, Provider will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available.

  All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider policy to the contrary.
- **Completion of Audit (On-site Audit only).** Upon completion of the Audit, Anthem or its designee will generate and give to Provider a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit.

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

  If the Provider agrees with the Audit findings and has no further information to provide to Anthem or its designee, then Provider may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider disagree with the final Audit Report generated during the exit interview, then Provider may either supply the requested documentation or Appeal the Audit findings.
- **No Appeal (On-site audit only).** If the Provider does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.
- **Scheduling of Audit (Hospital Bill Audits Only).** After review of the documents submitted, if Anthem or its designee determines an Audit or Review is required, Anthem or its designee will

call the Provider to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

- **Rescheduling of Audit**. Should Provider desire to reschedule an Audit, Provider must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's rescheduling. While Anthem or its designee prefers to work with the Provider in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider to schedule an Audit within the seventy-two (72) hour timeframe.
- **Under-billed and Late-billed Claims**. During an on-site audit, Provider may identify Claims for which Provider under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider before the Audit commences will not be evaluated in the Audit.

Audit Appeal Policy

**Purpose**

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

**Procedure**

- Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the findings in the Notice of Overpayment. An Appeal of the Notice of Overpayment must be in writing and received by Anthem or its designee within forty-five (45) calendar days of the date of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Appeal should address the findings from the Notice of Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the forty-five (45) calendar days unless expressly prohibited by contractual obligations or applicable law.
- Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Anthem's or its designee's response shall be sent via email, mail or portal to the Provider or Facility within forty-five (45) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation.
- The Provider or Facility shall have thirty (30) calendar days from the date of Anthem's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the thirty (30) calendar day timeframe,

Anthem or its designee shall begin recoupment of the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.

- Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Anthem's or its designee's final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation.
- If applicable in the state, the Provider or Facility shall have thirty (30) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the thirty (30) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response.

# Fraud, Waste and Abuse Detection

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

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

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

## Reporting Fraud, Waste and Abuse

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

Report concerns:

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

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

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

- Forging, altering or selling prescriptions
- Letting someone else use the Member’s ID (Identification) card
- Relocating to out-of-service Plan area and not letting the Plan know
- Using someone else’s Member ID card

When reporting concerns involving a Member include:

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

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

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- Overutilization
- Soliciting, offering or receiving kickbacks or bribes
- Unbundling – when multiple procedure codes are billed individually for a group of procedures 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 health care fraud and how to aid in the prevention on it, visit **fighthealthcarefraud.com.**

## Investigation Process

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

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

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

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

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

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

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

## SIU Prepayment Review

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

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

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Anthem in accordance with this requirement will result in a denial of the Claim under review. During the pendency of the prepayment review, if requested, the Provider or Facility will be given the opportunity to discussion of their prepayment review status.

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

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

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

## Acting on Investigative Findings

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

## Recoupment/Offset/Adjustment for Overpayments

Anthem 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 the Agreement or under any Agreement between Provider and an Affiliate regardless of the cause.

Provider or Facility shall voluntarily refund the Overpayment Amount regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful.

Upon determination by Anthem that an Overpayment Amount is due from Provider or Facility, Provider or Facility must refund the Overpayment Amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility.

If the Overpayment Amount is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset the unpaid portion of the Overpayment Amount against other Claims payments due and payable by Anthem or an Affiliate to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements.

In such event, Provider or Facility agrees that all future Claim payments, including Affiliate Claim payments, applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been legally paid to Provider or Facility in full for all purposes, including Affiliates and/or Regulatory Requirements as defined by the Provider or Facility Agreement.

*Timeframes for recoupment/offset/adjustment for overpayments is three-hundred sixty-five (365) days for professional and facility fully insured claims subject to the Virginia Ethics and Fairness in Carrier Business Practices Act. Anthem may extend this timeframe beyond three-hundred sixty-five (365) days with the providers permission subject to the Virginia Ethics and Fairness in Carrier Business Practices Act.

For claims not subject to the Virginia Ethics and Fairness in Carrier Business Practices Act, as long as we ask for the refund within eighteen (18) months of the EOP, there is no limitation on the recoupment/offset/adjustment timeframe.

In addition, for all Commercial claims, Anthem can send a refund request letter for overpayments that are outside of the scope of recoupment/offset/adjustment timeframes within eighteen (18) months from EOP.

Medicare Advantage claims have a three (3)-year recovery lookback period for recovery efforts.

Medicaid claims have an eighteen (18)-month lookback period for recovery efforts.

Federal Employees Health Benefit Plans claims have a five (5)-year recovery lookback period for recovery efforts.

Veteran Affairs claims have an eighteen (18)-month lookback period for recovery efforts.

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

Anthem reserves the right to employ a third-party collection agency in the event of non-payment.

# Pharmacy & Prescriber Home Program

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

One of the primary goals of the Pharmacy & Prescriber Home Program is to help reduce overutilization of controlled substance medications. 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 reduces risk through increased communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy and/or prescriber Provider. The pharmacy and/or prescriber Provider is selected by the Member or is assigned based on the retrospective Drug Utilization Review (DUR) of their prescription Claims history if no selection is made during the allotted enrollment period. Following the selection of the Member's new Pharmacy and/or Prescriber Home, all of the Member's prescribing physicians will receive notification of the Member's enrollment into the program, the assigned pharmacy/prescriber information and a three (3) month prescription profile containing a list of controlled substance prescribers, medications, dosages, and quantities received by the Member during that timeframe.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy or prescriber for all prescribed Schedule II-V controlled medications for a period of no less than twelve (12) consecutive months. This assigned Provider, or Pharmacy/Prescriber Home, will write and/or fill the Member's controlled substance medications throughout the term of their enrollment in this program.

**The Pharmacy & Prescriber Home Program includes:**

- Reimbursement of Controlled Substance Claims when written by the designated prescriber and/or filled at the Member's Pharmacy Home. All controlled substance Claims are denied if written by any prescriber or filled at any pharmacy other than the Member's assigned Pharmacy or Prescriber Home.
- Temporary overrides for urgent or emergent situations only.[1]
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

**Criteria**

A Member whose prescription Claims' history shows they meet the below inclusion criteria may be enrolled in the Pharmacy & Prescriber Home Program if:[2]

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a ninety (90)-day period.

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

**Communications to Members**

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

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

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

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

# 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 Virginia, go to **anthem.com/provider/news/** and select Virginia.

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

**Important Reminder**

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

# Federal Employees Health Benefits Program (FEHBP)

## FEHBP Requirements

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

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

## Submission of Claims under the FEHBP

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

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

## Omnibus Budget Reconciliation Act of 1993 (OBRA '93)

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

to family Members covered by a family enrollment of an annuitant or former spouse. The covered Member must:

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

## Erroneous or Duplicate Claim Payments under the FEHBP

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

## Coordination of Benefits for FEHBP

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

## FEHBP Waiver Requirements

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

## FEHBP Member Reconsiderations and Appeals

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

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

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

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

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

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

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

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

## FEHBP Formal Provider and Facility Appeals

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

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

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

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

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

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

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

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

### FEHBP Inpatient Skilled Nursing Facility Care

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

### Online information for FEHBP

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

# BlueCard® Program Overview

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

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online go to **anthem.com**, select **For Providers**, select **Policies, Guidelines & Manuals**, scroll down and select "**Download the Manual**", scroll to the Provider Manual Library section and choose **BlueCard Provider Manual**.

See the **Provider Professional Billing Guidelines** section for some Virginia specific information regarding BlueCard.

# Medicare Advantage

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

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

**Medicare Advantage Provider Guidebook**

# Important Links

**Other Valuable Company Resources**

**Contact Us:** (Listing of useful Telephone numbers)
**anthem.com/provider/contact-us/**

**Provider News:** Newsletter and email notifications
**providernews.anthem.com/virginia**

**Electronic Data Interchange (EDI)**
**anthem.com/edi**

**Coverage Guidelines and Clinical UM Guidelines Link**
**anthem.com/provider/policies/clinical-guidelines/virginia/**

**BlueCard Website**
**bcbs.com**

**Federal Employee Program (FEP) Website**
fepblue.org

**Medicare Advantage**
**anthem.com/medicareprovider**

**Medicaid Provider Website**
**anthem.com/mediproviders**

# Physician Office HMO Lab List for Virginia

This Physician Office Lab List applies to HMO (HealthKeepers & HealthKeepers Plus) networks only.

| | |
|---|---|
| **80047** | BASIC METABOLIC PANEL (Calcium, ionized) |
| **80048** | BASIC METABOLIC PANEL (Calcium, total) |
| **80051** | ELECTROLYTE PANEL |
| **80061** | LIPID PANEL |
| **80069** | RENAL FUNCTION PANEL |
| **80178** | LITHIUM |
| **80305** | DRUG TEST(S), PRESUMPTIVE, ANY NUMBER OF DRUG CLASSES |
| **81000** | URINALYSIS, BY DIP STICK OR TABLET REAGENT |
| **81001** | URINALYSIS; AUTOMATED, WITH MICROSCOPY |
| **81002** | URINALYSIS; NON-AUTOMATED WITHOUT MICROSCOPY |
| **81003** | URINALYSIS; AUTOMATED, WITHOUT MICROSCOPY |
| **81015** | URINALYSIS; QUALITATIVE OR SEMIQUANTITATIVE, MICROSCOPIC ONLY |
| **81025** | URINE PREGNANCY TEST, BY VISUAL C |
| **82010** | KEYTONE BODY(S)(EG ACETONE, ACETOACETIC ACID, BETA |
| **82040** | ALBUMIN; SERUM, PLASMA OR WHOLE BLOOD |
| **82044** | ALBUMIN; URINE (E.G.MICROALBUMIN) SEMIQUANTITATIVE (E.G., REAGENT STRP ASSAY) |
| **82120** | AMINES, VAGINAL FLUID, QUALITATIVE |
| **82150** | ASSAY OF AMYLASE |
| **82247** | BILIRUBIN; TOTAL |
| **82248** | BILIRUBIN; DIRECT |
| **82270** | BLOOD, OCCULT; FECES, SCREENING, |
| **82271** | BLOOD, OCCULT, BY PEROXIDASE ACTIVITY QUALITATIVE |
| **82272** | BLOOD, OCCULT, BY PEROXIDASE ACTIV |
| **82465** | ASSAY BLD/SERUM CHOLESTEROL |
| **82550** | ASSAY OF CK (CPK) |
| **82570** | ASSAY OF URINE CREATININE |
| **82679** | ESTRONE |
| **82948** | BLOOD, REAGENT STRIP |
| **82950** | POST GLUCOSE DOSE (INCLUDES GLUCOSE) |
| **82951** | TOLERANCE TEST (GTT), THREE |

| | |
|---|---|
| **82952** | TOLERANCE TEST, EACH ADDITIONAL |
| **82962** | GLUCOSE, BLOOD, BY GLUCOSE MONITOR |
| **82977** | ASSAY OF GGT |
| **82985** | ASSAY OF GLYCATED PROTEIN |
| **83001** | ASSAY OF GONADOTROPIN (FSH) |
| **83002** | ASSAY OF GONADOTROPIN (LH) |
| **83014** | HELICOBACTER PYLORI; DRUG ADMINISTRATION |
| **83026** | HEMOGLOBIN, BY COPPER SULFATE METHOD, NON-AUTOMATED |
| **83036** | HEMOGLOBIN; GLYCOSYLATED (A1C) |
| **83037** | HEMOGLOBIN; GLYCOSYLATED (A1C) BY DEVICE CLEARED BY FDA FOR HOME USE |
| **83516** | IMMUNOASSAY NONANTIBODY |
| **83605** | LACTATE (LACTIC ACID) |
| **83655** | LEAD |
| **83718** | LIPOPROTEIN, DIRECT MEASUREMENT; HIGH DENSITY CHOLESTEROL (HDL) |
| **83721** | LIPOPROTEIN, DIRECT MEASUREMENT; LDL CHOLESTEROL |
| **83861** | Tear Osmolarity, microfluidic analysis utilizing integrate collection and analysis device |
| **83880** | NATRIURETIC PEPTIDE |
| **84075** | PHOSPHATASE, ALKALINE |
| **84155** | PROTEIN, TOTAL, EXCEPT BY REFRACTOMETRY; SERUM, PLASMA OR WHOLE BLOOD |
| **84443** | THYROID STIMULATING HORMONE (TSH) |
| **84450** | TRANSFERASE; ASPARTATE AMINO (AST) (SGOT) |
| **84460** | TRANSFERASE; ALANINE AMINO (ALT) (SGPT) |
| **84478** | TRIGLYCERIDES |
| **84550** | URIC ACID; BLOOD |
| **84703** | GONADOTROPIN, CHORIONIC (hCG); QUALITATIVE |
| **84830** | OVULATION TESTS, BY VISUAL COLOR COMPARISON METHOD |
| **85013** | SPUN MICROHEMATOCRIT |
| **85014** | OTHER THAN SPUN HEMATOCRIT |
| **85018** | HEMOGLOBIN |
| **85025** | HEMOGRAM AND PLATELET COUNT, |
| **85027** | HEMOGRAM AND PLATELET COUNT, |
| **85610** | PROTHROMBIN TIME; |
| **85651** | SEDIMENTATION RATE, ERYTHROCYTE; NON-AUTOMATED |
| **85652** | SEDIMENTATION RATE, ERYTHROCYTE; AUTOMATED |

| | |
|---|---|
| **86140** | C-REACTIVE PROTEIN |
| **86294** | IMMUNOASSAY FOR TUMOR ANTIGEN, QUALITATIVE OR SEMIQUANTITATIVE |
| **86308** | HETEROPHILE ANTIBODIES; SCREENING |
| **86318** | IMMUNOASSAY FOR INFECTIOUS AGENT ANTIBODY, QUALITATIVE |
| **86328** | Immunoassay for infectious agent antibody(ies), qualitative or semiquantitative, single step method (e.g., reagent strip); severe |
| **86408** | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); screen |
| **86409** | Neutralizing antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]); titer |
| **86413** | Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) antibody, quantitative |
| **86580** | TUBERCULOSIS, INTRADERMAL |
| **86701** | HIV-1 |
| **86769** | Antibody; severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]) |
| **86780** | ANTIBODY; TREPONEMA PALLIDUM |
| **86803** | HEPATITIS C ANTIBODY |
| **87077** | CULTURE, BACTERIAL DEFINITIVE; AEROBIC ISOLATE, ADDITIONAL METHODS |
| **87081** | Culture presumptive, pathogen, organisms, screening (covered for Medicaid per DMAS effective 6/1/2021) |
| **87210** | WET MOUNT WITH SIMPLE STAIN, |
| **87220** | TISSUE EXAMINATION FOR FUNGI |
| **87426** | Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent |
| **87428** | Infectious agent antigen detection by immunoassay technique, (e.g., enzyme immunoassay [EIA], enzyme-linked immunosorbent |
| **87449** | INFECTIOUS AGENT ANTIGEN DETECTION BY ENZYME IMMUNOASSAY |
| **87502** | INFLUENZA, FOR MULTIPLE TYPES OR SUB-TYPES |
| **87631** | INFECTIOUS AGENT DETECTION BY NUCLEAIC ACID (DNA OR RNA); |
| **87633** | INFECTIOUS AGENT DETECTION BY NUCLEAIC ACID (DNA OR RNA) |
| **87634** | RESPIRATORY SYNCYTIAL VIRUS, AMPLIFIED PROBE TECHN |
| **87635** | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)… |
| **87636** | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)… |
| **87637** | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)… |

| | |
|---|---|
| **87651** | STREPTOCOCCUS, GROUP A, AMPLIFIED PROBE TECHNIQUE |
| **87804** | INFECTIOUS AGENT ANTIGEN DETECTION: INFLUENZA |
| **87807** | INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY; RSV |
| **87808** | TRICHOMONAS VAGINALIS |
| **87809** | INFECTIOUS AGENT ANTIGEN DETECTION BY IMMUNOASSAY; ADENOVIRUS |
| **87811** | Infectious agent antigen detection by immunoassay with direct optical (i.e., visual) observation; severe acute respiratory syndrome… |
| **87880** | INFECTIOUS AGENT ANTIGEN DETECTION: STREP, GROUP A |
| **87905** | INFECTIOUS AGENT ENZYMATIC ACTIVITY OTHER THAN VIR |
| **0202U** | Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including… |
| **0223U** | Infectious disease (bacterial or viral respiratory tract infection), pathogen-specific nucleic acid (DNA or RNA), 22 targets including… |
| **0224U** | Antibody, severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19]), includes titer(s)… |
| **0225U** | Infectious disease (bacterial or viral respiratory tract infection) pathogen-specific DNA and RNA, 21 targets, including severe acute… |
| **0226U** | Surrogate viral neutralization test (sVNT), severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease… |
| **0240U** | Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 3 targets (severe acute respiratory syndrome… |
| **0241U** | Infectious disease (viral respiratory tract infection), pathogen-specific RNA, 4 targets (severe acute respiratory syndrome… |
| **C9803** | Hospital outpatient clinic visit specimen collection for severe acute respiratory syndrome coronavirus 2 (sars-cov-2)… |
| **G2023** | Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])… |
| **G2024** | Specimen collection for severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (Coronavirus disease [COVID-19])… |
| **U0001** | CDC 2019 novel coronavirus (2019-ncov) real-time RT-PCR diagnostic panel |
| **U0002** | 2019-nCov Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19) using any technique, multiple types or subtypes (includes all targets) |
| **U0003** | Infectious agent detection by nucleic acid (DNA or RNA); severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2)… |
| **U0004** | 2019-nCoV Coronavirus, SARS-CoV-2/2019-nCoV (COVID-19), any technique, multiple types or subtypes (includes all targets)… |
| **U0005** | Infectious agent detection by nucleic acid (dna or rna); severe acute respiratory syndrome coronavirus 2 (sars-cov-2) … |

**Medicaid:** Not all services on this list may be paid in the Provider office; Anthem follows guidance from DMAS on coverage determination.