Anthem Blue Cross

California Facility and Professional Provider Manual

Effective January 1, 2025

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Introduction and Guide to Manual

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

To that end, 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/ca,** a few key topics are:

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

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

Provider versus Facility

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

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

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

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

Capitalization

Capitalized terminology shown in this Manual is the same capitalized terminology shown in the Anthem Facility Agreement or Anthem Agreement, referred to in this Manual as Agreement. The provisions in this Manual apply unless otherwise required by the Agreement.

Updates to the Provider Manual

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

Important disclaimer

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

Legal and Administrative Requirements

Admission, Discharge and Transfer Messaging Data

Facilities must provide Anthem with, at minimum, Health Level Seven International (HL7) Admission, Discharge and Transfer (ADT) messaging data for all Members on a near real-time basis, including all standard HL7 message events pertaining to ADT as published by HL7. Facility will transfer required message data segments according to the standard HL7 format, or as requested by Anthem. For purposes of this section, "near real-time basis" means no later than twenty-four (24) hours from admission, discharge or transfer of any Members.

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/ca**, select **For Providers**, select **Forms & Guides** (under the Provider Resources column), then scroll down and select **Contracting & Updates** in the Category drop down and select **Affiliated Companies**.

Clinical Data Sharing

Anthem requires Providers and Facilities to submit clinical data when requested. For details on how to submit clinical data, review the administrative policy by visiting **anthem.com/ca**, select **For Providers**, select **Forms and Guide** (under the Provider Resources column), then scroll down and select **Administrative Policies** in the Category drop down and select **Clinical Data Sharing.**

Commercial Access Standards

Anthem is committed to keeping Providers and Facilities updated on activities related to compliance with the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) Timely Access to Non-Emergency Health Care Services Regulations (the "Timely Access Regulations"), respectively. Anthem maintains policies, procedures, and systems necessary to ensure compliance with the Timely Access Regulations, including access to non-emergency health care services within prescribed timeframes (also referred to as the "time elapsed standards" or "appointment wait times"). Anthem can only achieve this compliance with the help of Provider network partners. There are many activities that are conducted to support compliance with the regulations and Anthem needs Providers and Members to help attain the information that is needed. These studies allow Anthem to determine compliance with the regulations.

The activities include, but are not limited to the following:

- Provider Appointment Availability Survey
- Provider Satisfaction Survey
- Provider After – Hours Survey

Anthem appreciates that in certain circumstances time-elapsed requirements may not be met. The Timely Access Regulations have provided exceptions to the time-elapsed standards to address these situations:

Extending Appointment Wait Time

The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.

Preventive Care Services and Periodic Follow-up Care

Preventive care services and periodic follow up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care provider acting within the scope of his or her practice. Periodic follow-up care includes but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.

Advanced Access

The primary care appointment availability standard may be met if the primary care physician office provides “advanced access.” “Advanced access” means offering an appointment to a patient with a primary care physician (or nurse practitioner or physician’s assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day). *Note:* This exception does not apply to Behavioral Health.

Access Standards for Medical Professionals

Access to	Standard
Non-urgent appointments for Primary Care (PCP)	Must offer the appointment within 10 business days of the request
Urgent Care appointments not requiring prior authorization	Must offer the appointment within 48 hours of request
Non-urgent appointments with Specialist Physicians	Must offer the appointment within 15 business days of the request
Urgent Care (that requires prior authorization)	Must offer the appointment within 96 hours of request
Non-urgent appointment for ancillary services (for diagnosis or treatment of inquiry, illness, or other health condition)	Must offer the appointment within 15 business days of the request
In-office waiting room time	Usually, Members do not wait longer than 15 minutes to see a physician or his/her designee

Access to	Standard
After Hours Care	Member to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back
Emergency Care Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the Member to call 911 or go the emergency room if the caller is experiencing an emergency)	Immediate Access to Emergency Care. Members are directed to 911 or the nearest emergency room
Member Services by Telephone. Access to Member Service to obtain information about how to access clinical care and how to resolve problems (this is a plan responsibility and not a physician responsibility; and this also applies to Behavioral Health Members)	Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate <5%. The Member NurseLine is available 24/7 and the wait time is not to exceed 30 minutes.

For further questions, visit the ***Contact Us*** page on **anthem.com/ca** for self-service tools and up-to-date contact information: **anthem.com/ca/provider/contact-us.**

Access Standards for Behavioral Health and EAP Providers

Type of Care	Standard
Emergency Care Instructions (Anthem Blue Cross expects every practitioner to instruct their after-hours answering service staff that if the caller is experiencing an emergency, the caller should be instructed to dial 911 or to go directly to the emergency room. Answering machine instructions must also direct the Member to call 911 or go the emergency room if the caller is experiencing an emergency) Members are directed to 911 or the nearest emergency room.	Members are directed to 911 or the nearest emergency room.
Non-Life Threatening Emergency Care	Appointment within 6 hours Members are directed to 911 or the nearest emergency room.
Urgent Care (does not require prior authorization)	Appointment within 48 hours Members are directed to 911 or the nearest emergency room.
Urgent Care (requires prior authorization)	96 hours

Type of Care	Standard
Routine Office Visit/Non-urgent Appointment	10 Business days (Psychiatrists)** 10 Business days (Non-Physician Mental Health Care Providers/Substance Use Disorder) 10 business days from the prior appointment for those undergoing a course of treatment (Non-Physician Mental Health Care/Substance Use Disorder) 5 Business days (EAP)
Access to After-hours Care	Available 24 hours/7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP Provider and be informed when the call will be returned.
In Office Waiting Room Time	Usually, Members do not have to wait longer than 15 minutes after their scheduled appointment to see a Behavioral Health/EAP Provider.

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

- The next available appointment date and time can be either In-Person or by Telehealth services.
- Only appropriately qualified staff, a physician, physician assistant, nurse practitioner or registered nurse are allowed to provide triage or screening clinical advice.

Referrals to specialists

A referral to a specialist by a primary care provider or another specialist shall be subject to the relevant timely access standards.

Members also have access to Anthem's 24/7 NurseLine. The NurseLine wait time is not to exceed thirty (30) minutes. The phone number is located on the back of the Member ID card. In addition, Members and Providers have access to Anthem's Customer Service team at the telephone number listed on the back of the Member ID card. A representative may be reached within ten (10) minutes during normal business hours.

Contact the Anthem Member Services team at the telephone number listed on the back of the Member ID card to obtain assistance if a patient is unable to obtain a timely referral to an appropriate Provider.

For Patients (Members) with Department of Managed Health Care Regulated Health plans

If Providers or Members are unable to obtain a timely referral to an appropriate Provider or for additional information about the regulations, visit the Department of Managed Health Care's website at **healthhelp.ca.gov** or call toll-free **888-466-2219** for assistance.

For Patients (Members) with California Department of Insurance Regulated Health plans

If Providers or Members are unable to obtain a timely referral to an appropriate Provider or for additional information about the regulations, visit the Department of Insurance's website at **insurance.ca.gov** or call toll-free **800-927-4357** for assistance.

Language Assistance Program

For Members whose primary language is not English, Anthem offers at no cost, language assistance services through interpreters and other written languages. If Providers or Members are interested in these services, call the Anthem Member Services number on the Member's ID card for help (TTY/TDD: 711).

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

See Section: **Language Assistance Program**

Coordination of Benefits

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

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

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 of Coordination of Benefit Claims electronically. If Providers and Facilities would like to learn more, contact the EDI vendor.

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

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.

Member and Third-Party Liability

Member Liability

The only charges for which the Member may be liable, and may be billed by Facility, are the following items:

1. Facility services not covered by the Member's Benefit Agreement. However, for health services that are not Medically Necessary or are experimental/investigational refer to number 3 below.
2. Copayments, coinsurance and deductible amounts required by the Member's Benefit Agreement, as long as Customer Service has been contacted to verify the Member's responsibility (i.e., whether or not the Member has satisfied his or her respective deductible).
3. Health services that are not Medically Necessary, but agreed to by the Member in advance, in writing, on a waiver form [also called the Member (Patient) Responsibility Agreement] approved by Anthem, which informs the Member that the services are likely not to be deemed Medically Necessary or are likely to be non-covered due to being experimental or investigational, and which includes an estimate of the cost of the services to which the Member is agreeing to pay. A sample of the **Member (Patient) Responsibility Agreement** can be found in the **Exhibits** section of this Manual.

The Facility may not charge the Member for upgrades on durable medical equipment (DME) or other services generally not covered under the Member's Benefit Agreement, unless the Member has agreed to cover such upgrades in writing, by signing a waiver form approved by Anthem. A sample of the **Member (Patient) Responsibility Agreement** can be found in the **Exhibits** section of this Manual. This Agreement must be made in advance and with knowledge of Anthem's lack of medical necessity determination. For the waiver form to be valid, the enrollee must sign it.

The waiver form should indicate the full amount the Facility is billing for the service/equipment and the amount the Member has agreed to as his or her responsibility. To avoid processing delays, submit the waiver form with the Claim.

Members are not liable for any Stop Loss balances after reaching their benefit maximum.

Members who are injured workers are not responsible for payment of any compensable medical care and cannot be balanced billed under California Workers' Compensation Act and the terms of the Anthem Facility Agreement.

Third-Party Liability

Occasionally, a Facility may treat a Member for a condition, illness, or injury for which another person or entity may be liable or legally responsible for causing. Under many Anthem Benefit Agreements, Anthem pays the treatment costs associated with such conditions, illnesses or injuries, if they are otherwise covered by the Benefit Agreement.

Anthem may have a right under the Member's Benefit Agreement to seek reimbursement for the benefits it pays for this treatment from a third party or third-party's insurer. However, neither this right to

reimbursement nor the fact that Anthem may have been reimbursed, in whole or in part, for a particular benefits payment renders the medical services noncovered under the Member's Agreement.

Under their Agreements with Anthem, Facilities have agreed to accept a negotiated rate as payment in full for services rendered to Anthem Members. Facilities will bill Anthem directly and may look to responsible third parties for certain limited costs (i.e., deductible and copayment amounts). However, Facilities may not look to third parties for any amounts that would exceed the negotiated rate (e.g., the difference between the negotiated rate and the Facility's Total Eligible Billed Charges). In addition, Facilities may not look to the responsible third party for the negotiated rate if Anthem has already issued payment. To do so would result in double compensation to the Facility.

When a third party may be liable, Facilities should notify the Anthem Third-Party Liability department at the toll-free phone number **1-800-645-9785**.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact the Anthem associate and/or department who initiated the misrouted PHI. If Providers or Facilities are unable to locate the contact information for the misrouted PHI, then Providers or Facilities to contact the assigned Provider Experience associate or visit the **Contact Us** page on the provider website for up-to-date contact information: **anthem.com/ca/provider/contact-us**

Open Practice

Provider shall notify Anthem within five (5) business days, if Provider, or any provider within Provider's group, (i) is no longer accepting new patients or (ii) if Provider or any provider within Provider's group who was previously not accepting new patients is now open to new patients. Providers contracted with Anthem should utilize Availity's Provider Demographic Management (PDM) application hosted on **Availity.com** to request changes to existing practice information.

Provider and Facility Data Verification Required

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

Providers and Facilities 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.

Provider and Facility Digital Engagement

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

Provider and Facility Responsibilities

Providers and Facilities are obligated to abide by responsibilities outlined in the Agreement, as well as those discussed in this Manual.

Note: FEP PPO Members, in order to maximize their benefits, must access the Blue Shield of California contracted Provider network.

Provider responsibilities include, but are not limited to:

- Provide timely service. The Providers will administer medically necessary services, in accordance with the applicable Member health care plan(s). Providers will maintain practice policies supporting the provision of medical services to Members, within the specified intervals between a Member's request for service and the date/time medical services are rendered. If there is a significant interruption in the Provider's ability to maintain these standards, Anthem Blue Cross must be notified in writing. The Provider will see, accept and maintain, to the extent possible, evidence of payment for medical services provided to Members under the plan Agreement.
- Provide for the availability of emergency services twenty-four (24) hours a day, seven (7) days a week, and arrange for coverage by another Provider in the event of a Provider's illness, vacation, or absence from his or her practice. If the covering Provider is nonparticipating, he or she will use his or her best efforts to have the covering Provider abide by the terms of the Agreement

  Anthem Blue Cross
  P.O. Box 60007
  Los Angeles, CA 90060-0007

  For FEP PPO Members, notify:
  Anthem Blue Cross
  P.O. Box 272510
  Chico, CA 95927

Or by phone at **800-824-8839**

- Providers agree to admit or arrange for the admittance of Members only to participating hospitals, unless admission to a nonparticipating hospital is either authorized in advance by Anthem Blue Cross for good cause or in case of emergency. See *Referrals to Nonparticipating Providers* in the subsection of this section.
- Providers also agree to refer Members to participating outpatient surgical centers (outpatient surgical centers, also known as ambulatory surgical centers, are independent medical facilities [not hospitals] where surgical procedures that do not require more than a twelve (12)-hour stay are performed) and other participating health care Providers in all circumstances, except when authorization to refer a Member to a nonparticipating surgical center or health care Provider has been granted in advance by Anthem Blue Cross, or when necessary due to an emergency.
- Failure to admit Members to participating hospitals, mental health facilities or refer Members to participating outpatient surgical centers and health care Providers in nonemergency situations without the approval of Anthem Blue Cross will be grounds for action by Anthem Blue Cross, including, but not limited to, termination from the Anthem Blue Cross Network.
- Cooperate with Anthem Blue Cross' Quality Improvement Program.
- The Provider must participate in Anthem Blue Cross' or other payor's Utilization Management (UM) program, and agree to cooperate with Anthem Blue Cross' administration of its internal quality-of-care review and grievance resolution procedures.
- Providers must use their best efforts to prescribe generic drugs, as appropriate, and drugs contained in the Anthem Blue Cross Outpatient Prescription Drug Formulary to Members. See the Pharmacy Program and Guidelines section of this Manual for further information.
- Allow Anthem Blue Cross access to medical records to the extent allowed by federal and state law.
- Maintain the confidentiality of Member information and records, and comply with Anthem Blue Cross' Notice of Privacy Practices and associated Health Insurance Portability and Accountability Act (HIPAA) standards.
- Openly communicate with patients about their treatment, regardless of benefit coverage limitations. It is Anthem Blue Cross' policy that UM decision-making is based only on appropriateness of care and service, and existence of coverage. The organization does not specifically reward Providers or other individuals for issuing denials of coverage or service. There are no financial incentives for UM decision-makers to encourage decisions that may result in underutilization.
- If a Member seeking medical services from a physician is identified as being in the first trimester of pregnancy, or is on the first visit for the condition, and if the pregnancy appears to be ongoing, the physician will refer the Member to the Anthem Blue Cross Future Moms program. The telephone number for enrollment in the Future Moms program is **866-664-5404**. For more information about the Future Moms program and other health improvement resources, refer to the *360° Health*® section of this Manual. For FEP PPO Members, Members may call **800-828-5891**.

Notification Responsibilities

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

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

- adding new or removing practitioners to the group
- change in ownership
- change in Tax Identification Number
- making changes to demographic information or adding new locations
- selling or transferring control to any third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business or corporation

SB 137 Anthem Provider Directory

California enacted a Provider directory law commonly referred to as SB 137 found at California Health & Safety Code §1367.27 of the Knox-Keene Health Care Service Plan Act of 1975, as amended (Health and Safety Code Section 1340, et seq.), and §10133.15 of the California Insurance Code.

SB 137 was effective July 1, 2016. SB 137 reflects the importance of ensuring that participating Providers' and Facilities' demographic information is up to date, and that any changes to Provider or Facility demographics are communicated by the Provider or Facility to the health plan in a timely manner.

Facilities and Providers must respond timely to Anthem's, or Anthem's designee's, regular or follow-up outreach to confirm Provider Directory information.

Referring to Non-participating Providers

Anthem's mission is to provide affordable quality health care benefits to its Members. Members access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Members at risk of higher out-of-pocket expenses when they refer to non-participating providers in non-emergent situations or without Anthem's prior approval. Anthem has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Member in most situations rather than the non-participating provider; and Members may be balance billed by non-participating providers for the difference between the amount they charge for the service and the amount paid to that non-participating provider.

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

there may be instances in which Providers and Facilities must refer to a non-participating provider. For additional information on in-network and out-of-network referrals, Providers and Facilities should refer to the applicable sections of their Agreement with Anthem.

In circumstances where a referral to a nonparticipating Provider is necessary, the Provider agrees to contact Anthem Blue Cross by calling **800-274-7767** to request authorization. For FEP PPO, contact Blue Shield of California at **800-824-8839**.

If the Provider must admit a Member to a nonparticipating hospital or mental health Facility or refer a Member to a nonparticipating outpatient surgery center or health care Provider, the Provider must document that he or she has given the Member notice of the following by using the *Advanced Patient Notice for Use of a Nonparticipating Provider* at this link **Advance Patient Notice Form.** Such notice informs the Member of the following to allow them to make an informed decision about utilizing a non-par Provider:

1. The Provider is not participating with Anthem.
2. The Member may be responsible for extra costs if he/she receives services from that nonparticipating Provider.
3. The Member can call Anthem before getting services to confirm his/her benefits and can call to obtain the names of participating Providers that can provide the recommended services.
4. The nonparticipating Provider will collect copayments, deductibles, coinsurance or other amounts that the Member will be required to pay under his/her benefit plan.
5. The Member is voluntarily choosing to get services from this nonparticipating Provider.

The Member may be responsible for extra costs if he/she receives services from that nonparticipating Provider.

The Member can call Anthem before getting services to confirm his/her benefits and can call to obtain the names of participating Providers that can provide the recommended services.

The nonparticipating Provider will collect copayments, deductibles, coinsurance or other amounts that the Member will be required to pay under his/her benefit plan.

The Member is voluntarily choosing to get services from this nonparticipating Provider.

Provider also agrees:

If they refer a Member to a nonparticipating Provider, they will use their best efforts to require the non-participating Provider to abide by the terms of the Agreement.

For Workers' Compensation, refer to the Workers' Compensation section of this Manual.

Risk Adjustment

Compliance with Federal Laws, Audits and Record Retention Requirements

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

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

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

Encounter Data for Risk Adjustment Purposes

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

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

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

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

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

RADV Audits

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

ICD-10 CM Codes

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

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

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

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

HHS record documentation requirements include:

- Patient's name and date of birth should appear on all pages of record.
- Patient's condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT), or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete and specific.

When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.

Physician's/Qualified Non-Physician's signature, credentials and date must appear on record and must be legible.

Status of Participation in the Anthem Blue Cross PPO Network

Provider responsibilities include but are not limited to:

Providers agree to notify Anthem Blue Cross, in writing, of each separate tax identification number.

Providers may have several different tax ID numbers, but if Providers wish to be paid as a participating Provider or if Providers wish to avoid denials, Providers must notify Anthem Blue Cross to assure that the contract is updated appropriately.

Maintain credentialing, either as part of a delegated group or as an individual Provider. To find out more, go to the Credentialing Section.

Notify Anthem Blue Cross within the later of the time period set forth in the Agreement or 120 days of Provider (including all specialists) terminations, per the contract "Termination" provision, in order to allow Anthem Blue Cross to notify all Members of any practitioner terminating that the Member has seen in the last rolling 12 months. Anthem Blue Cross will notify affected Member's dependent on the Provider's timely notification to Anthem Blue Cross. Members with acute chronic conditions, or those who are pregnant, may be allowed to continue with the practitioner at in-network benefit levels. Affected Members should be directed to call Anthem Blue Cross Customer Service for transition assistance. Note: Behavioral Health Providers review the Agreement for timeframes.

Physician agrees to provide Covered Medical Services to any and all Members until such time as Provider closes his/her practice and is no longer accepting new patients from any health plan with whom Provider contracts. Provider shall follow Anthem Blue Cross policies and procedures and applicable laws, regarding prompt written notice of such practice closure.

Providers must disclose to Anthem Blue Cross any interest in, affiliation with, or control they or their immediate family Members have in another health care professional when referring patients for medical, health or administrative services to that health care professional (including, but not limited to: pathology, radiology, imaging and surgery centers). The Provider agrees to disclose information, on request, that includes, but is not necessarily limited to: the Provider's or the Provider's immediate family Member's percentage of control, ownership or other interest in such medical, health or administrative Provider. If no ownership or control exists, an explanation of the existence and nature of any Agreement for referrals between the participating Provider and said health care professional must be provided to Anthem Blue Cross. For Workers' Compensation Members, see the Workers' Compensation section of the Manual. This section will specify regulatory requirements to ensure Providers are in compliance.

Anthem Blue Cross must be notified of any legal, ethical or other actions against Providers or their license; any change in professional liability insurance premiums as a result of malpractice suits; or any change in hospital privileges (reduction, suspension or termination). Such actions include, but are not limited to, actions by the applicable state regulatory board, professional associations or hospitals.

Providers authorize Anthem Blue Cross to receive reports, on demand, from state licensure agencies, professional associations and other organizations that maintain data relating to legal status, litigation and clinical performance history.

Providers agree to maintain hospital privileges appropriate to their specialty at a participating hospital, unless Anthem Blue Cross agrees otherwise (in advance and in writing).

Effective September 1, 2023, Providers with a specialty eligible to render care in a licensed ambulatory surgery center (ASC), unless Anthem agrees otherwise (in advance and in writing), agree to obtain ambulatory surgical services privileges with a participating ASC and maintain privileges with a participating ASC throughout the term of their Agreement.

Exceptions for appropriate specialty practices may be granted. **Note: Not applicable to behavioral health Providers unless practicing in a hospital setting.**

The Provider is required to practice in a peer-reviewed environment. Compliance is achieved through maintaining hospital privileges, practicing in a licensed ambulatory surgical center, or participating in other peer-reviewed activities approved by Anthem Blue Cross. **Note: Not applicable to behavioral health Providers unless practicing in a hospital setting.**

Other Payors

Anthem leases its Provider networks to third parties called “Other Payors”.

An alphabetic listing of these “Network Leasing Arrangements” payors can be accessed via Availity Essentials.

When the Anthem network is used by an Other Payor, the Provider/Facility agrees to provide medical services to Members of that Other Payor.

In all events, however, the Provider or Facility will look for payment only to the particular Other Payor that covers the medical services for which the Provider or Facility seeks to be compensated, except for applicable copayments or other obligations of Members. .

When an Other Payor uses the Anthem network, Provider/Facility will follow such Other Payor’s utilization review requirements regarding the determination of medical necessity and appropriateness of services provided, as well as other designated requirements.

Workers’ Compensation

In the event a Member seeks services for a work-related illness or injury and is covered for Workers’ Compensation benefits by a Workers’ Compensation Other Payor, the Provider/Facility agrees to provide medically necessary services, and complete a Provider’s/Facility’s first report of services, unless the Provider/Facility has elected to opt-out of the Workers’ Compensation program participation in accordance with their Agreement.

The Provider/Facility will receive compensation in accordance with the compensation set forth in their Agreement for services to Worker’s Compensation Members. If the Member requires additional treatment beyond that provided at the first visit, the Provider/Facility agrees to refer the Member only to a participating Provider/Facility in Anthem’s Worker’s Compensation program.

Directory of Services/Provider Resource Information

This section provides a directory of contacts to help health care professionals access the resources they need at Anthem. The directory identifies service units and Anthem personnel that have the required expertise to address questions, issues and concerns. For additional information, access the Anthem website at **anthem.com/ca,** select ***For Providers***.

Service Departments:	Contact Information:
Carelon Medical Benefits Management, Inc.: Non-emergency diagnostic imaging procedures, radiology, cardiology, specialty pharmacy, sleep studies, Cancer Care Quality Program.	(877) 291-0360 M-F, 7 a.m. to 5 p.m. Carelon Medical Benefits Management's Provider Portal is available 24 hours a day, 7 days a week via: **providerportal.com/**
Ancillary – CA Enterprise Ancillary Contract Support: Ambulance, Audiology, Cardiac Event Monitoring, Dialysis, DME, Hearing Aid Dispensers, Home Health, Home Infusion, Hospice, Lab, Outpatient Therapy (PT/OT/ST), Skilled Nursing Facilities.	**EnterpriseAncillary@Anthem.com**
Ancillary: Chiropractic, Acupuncture, and Registered Dieticians – Application requests, demographic changes, contract and fee schedule support, and provider administrative grievances should be directed to American Specialty Health (ASH)	American Specialty Health (800) 972-4226 **ashlink.com**
Anthem Blue Cross Life and Health Insurance Company	**anthem.com/ca**
Anthem Blue Cross Web Site	**anthem.com/ca**
Anthem Center for Medical Excellence for Transplant	(888) 574-7215 (877) 264-4540 (FAX)
Availity Essentials: Obtain eligibility, benefits, Claim status, secure messaging, EPA, Interactive Care Review and fee schedules.	**availity.com** 1-800-AVAILITY (282-4548) M-F, 5 a.m. to 4 p.m. PT
Behavioral Health Care Utilization Management/Utilization Review	(800)-274-7767 (877) 521-4787 (FAX) *Mailing Address:* Anthem Blue Cross Behavioral Health Attn: Care Management P.O. Box 17785 Denver, CO 80217-0785

Service Departments:	Contact Information:
BlueCard – Out of Area: The mechanism by which Anthem Blue Cross, as the host plan, arranges for payment of care rendered to Blue Cross and Blue Shield Member of out-of-state plans by the health care professional.	Eligibility & Membership: (800) 676-BLUE (2583) Claims Status: (800) 444-2726 BlueCard Doctor & Hospital Finder: (800) 810-2583 or **bcbs.com**
CA Provider Relationship **Behavioral Health (BH)** – Contract support for participating (already contracted) BH and Applied Behavior Analysis (ABA) providers (individuals and groups) and Facility. **Medical** – Contract support for participating (already contracted) Physicians, Hospitals, and Primary Medical Groups.	Contact your assigned Provider Relationship associate or visit: **anthem.com/ca/provider/contact-us** to view additional contact options.
CA – Joining the Network	Providers interested in joining our network should visit: **anthem.com/ca/provider/enrollment** Check status of a submitted application: Log in to Availity and search the dashboard to find the status of the application
CA Medicaid Health Plan: Administers Medicaid Managed Care Programs for California.	Medi-Cal: (800) 407-4627 Medi-Cal (LA Care Only): (888) 285-7801 Major Risk Medical Insurance Program (MRMIP)/ Medi-Cal Access Program: (formerly known as Carelon Medical Benefits Management): (877) 687-0549 Case Management: Contact appropriate number above Regional Health Plans: Central: (877) 811-3113 Northern: (888) 252-6331 Southern: (866) 465-2272
CA Medicaid Health Plan Utilization Management Prior- Authorizations	CA Medicaid: (888) 831-2246, Option 3 Alternate Number: (877) 273-4193, Option 2 Fax for all UM Prior Authorizations: (800) 754-4708 Medical injectable requests go to pharmacy: (866) 363-4126 Fax: (888) 708-2584
California Department of Insurance The California Department of Insurance (CDI) regulates insurers. Anthem Blue Cross Life and Health Insurance Company is regulated by the CDI. Anthem Blue Cross Life and Health Insurance Company Member should be directed to contact Anthem Blue Cross Life and Health if they have a question or complaint.	Inside California: (800) 927-HELP (4357) Outside California: (213) 897-8921 Telecommunication Device for the Deaf: (800) 482-4833 (TDD) Mailing Address: California Department of Insurance Consumer Services Division 300 South Spring St. South Tower Los Angeles, CA 90013 Email Address “Consumer” link at **insurance.ca.gov**

Service Departments:	Contact Information:
California Department of Managed Health Care – The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. For more information on grievance procedures, see the Member Grievances and Appeals Process section in this Manual.	Mailing Address: Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95817-2725 Health Plans Division Complaints: 888-HMO-2219 or (916) 255-5241 (Fax) Health Plans Division California Relay Service: (800) 735-2929 (TTY) DMHC internal TDD line(877) 688-9891 (TDD) DMHC's websites (online complaint forms and instructions): **healthhelp.ca.gov DMHC.ca.gov**
CalPERS	877-737-7776
Claims & Correspondence:	**All Claims and Claims-related correspondence, except for Federal Employee Program (FEP):** Anthem Blue Cross P.O. Box 60007, Los Angeles, CA 90060-0007 **All Facility Claims and Claims-related correspondence for Federal Employee Program:** Anthem Blue Cross P.O. Box 105557, Atlanta, GA 30348-5557 **All Professional Claims and Claims-related correspondence for Federal Employee Program:** Blue Shield of California P.O. Box 272510, Chico, California 95927 **Claims and correspondence via Federal Express, registered or certified mail, etc.:** Anthem Blue Cross/Name of Product. 21215 Burbank Blvd, Woodland Hills, CA 91367 **Workers' Compensation** – all related correspondence. Claims should be submitted directly to the Workers' Compensation payor: Anthem Workers' Compensation P.O. Box 70022, Anaheim, CA 92825-0022
Credentialing Status Inquiry Line	**credentialing@anthem.com.** This email is to be used only to check status of a submitted Provider application.

Service Departments:	Contact Information:
Customer Service All inquiries from Anthem Blue Cross PPO Members should be directed to the Customer Service department. In addition, Customer Service representatives assist Providers with a variety of administrative issues, including: • Eligibility verification and research • Benefit questions and explanations (except transplant) • Confirming if authorization or Utilization Management is required for services • Requests for Member removal following disciplinary actions • Claim status	Call the phone number on the back of the Member's ID card.
E-Solutions: Electronic Claims submission for Institutional, Medical & Dental only. ERA (835) electronic remittance advice) with no EFT request.	**anthem.com/edi** – select California (800) 470-9630 M-F, 8 a.m. to 4:30 p.m. PT Email: **E-Solutions.Support@anthem.com**
Employee Assistance Program (EAP) Networks: Contracts and manages the National EAP network in all 50 states plus the District of Columbia, Puerto Rico, US Virgin Islands and Guam.	**AnthemEAP.com** Fax: (888) 438-7957 M-F, 7 a.m. to 4 p.m. PT Email: **EAPProviderNetworks@anthem.com**
Federal Employee Program (FEP): A Fee-For-Service Plan funded by the government, for Postal and Non Postal Federal employees and their covered dependents. Facility Claims are managed by Anthem Blue Cross and Professional claims are managed by Blue Shield.	**fepblue.org** Facility Claims (Anthem Blue Cross): (800) 322-7319 PO Box 105557, Atlanta, GA 30348-5557 Inpatient Hospital Pre-Auth: (800) 633-4581 Professional Claims Customer Service (Blue Shield):
Financial Operations: Overpayment recovery	Large Group: (818) 234-3289 Individual Plans: (818) 234-3289 Small Group (818) 234-3289 BlueCard (800) 444-2726 Medicare Advantage (818) 234-3289 FEP (800) 824-8839

Service Departments:	Contact Information:
Grievance & Appeals: Formal dispute process for a Claim that has already been processed or when Providers and Facilities disagree with the final determination made on a Claim or clinical review.	**Grievance and Appeals Department** P.O. Box 60007 Los Angeles, CA 90060-0007 Provider Dispute Resolution (PDR) Form on **anthem.com/ca** Link: **Provider Dispute Resolution Form** PDR Form: **Availity.com** Link: **Anthem Blue Cross PDR Request Form** **Behavioral Health Grievances & Appeals Department** Anthem Blue Cross Behavioral Health Grievances & Appeals P.O. Box 4310, Woodland Hills, CA 91365-4310 (866) 333-4823 (TDD) (877) 487-7394 FAX **Members** Anthem Blue Cross Grievances and Appeals Department P.O. Box 4310 Woodland Hills, CA 91365-4310 (800) 365-0609 (866) 333-4823 (TDD) (877) 551-6183 (FAX) **Medicare Grievances & Appeals Department** Anthem Blue Cross Medicare Complaints Grievances & Appeals 4361 Irwin Simpson Rd OH0102-C535 Mason, OH 45040 Customer Service Number on Member ID Card (888) 458-1406 (FAX) **Medical Provider Network (MPN) Member** must call Anthem Workers' Compensation MPN Services (866) 700-2168
Health Insurance Marketplaces a.k.a. Exchanges	Benefits, Eligibility, Claims: Provider: (855) 854-1438 Member: (855) 453-7031 BH & Medical Contracting inquiries: Please visit the *Contact Us* page on the **provider website** for self-service tools and up-to-date contact information: **anthem.com/ca/provider/contact-us** Covered California Marketplace info: **http://www.coveredca.com/** UM Pre-Authorization: (800) 274-7767

Service Departments:	Contact Information:
Language Assistance Program	*Translation of materials:* Members contact (888) 254-2721 Providers contact on Members behalf: (800) 677- 6669 *Telephonic and In-person Interpretation:* Instruct Members to contact number on back of ID card. Providers: (800) 677-6669, request to speak to an interpreter or arrange for in-person interpreter services.
Pharmacy: Pharmacy benefit verification	Select "Member" option to verify eligibility & benefits for standard and specialty medications (800) 700-2541, M-F 8 a.m. to 5 p.m. PST Formulary Request (800) 700-2541 Management Customer Service (800) 700-2541 Prior Authorization of Pharmacy Benefits (PAB) Program Center (866) 310-3666 / (877) 327-8009 (Fax) Drug List (800) 870-6419 (for a Fax form & a list of specialty drugs) Customer Service (800) 870-6419 Speech & hearing-impaired assistance (800) 221-6915 (TDD/TTY)
Provider Care: Benefit, eligibility & Claims questions/issues. Grievance & Appeals Inquiries.	Refer to the service numbers on the back of the Member ID Card
Provider Data Management: Facilitates the data maintenance of provider information for Facility, Physicians & Ancillary Network providers, California Behavioral Health Network providers and Professional providers.	Providers contracted with Anthem Blue Cross should utilize Availity's Provider Demographic Management (PDM) application hosted on www.availity.com to request changes to existing practice information. Request data updates via either one of the following options within Availity Essentials PDM (available at no cost to care providers)*: **Multi-payer platform option:** Allows providers to make updates once and have that information sent to all participating health plans, submitting each change separately. **Roster upload option:** Allows providers to submit multiple updates within one spreadsheet via the Upload Rosters feature: The Upload Roster feature is currently only available, and shared with, Anthem. **Institutional Change Form.** Behavioral Health providers should use the Practice Profile and Practice Update Form. The forms are located on the Anthem Blue Cross website: **anthem.com/ca** > For Providers **>** Providers Overview > Forms > Provider Forms

Service Departments:	Contact Information:
Senior Services Medicare Advantage Anthem Medicare Preferred (PPO)	(877) 811-3107 M-F, 5 a.m. to 8 p.m. PT
Senior Services Medicare Supplement	(800) 333-3883
Specialty Pharmacy Medical Management: Medical Benefit Inquires only. Anthem UM Services	(800) 274-7767 - Option 4 M-F, 7:30 a.m. to 5 p.m. PT Fax: (866) 408-7195
Stop Loss: Facility stop loss inquiries should be directed to the number located on the back of the Member's ID card	If Providers and Facilities do not have a copy of the Member's ID card, call toll-free (800) 676-2583
Third Party Administrator (TPA) Groups: The Network Leasing Arrangements listing can be found on Availity. Log in to availty.com > Payer Spaces > Anthem Blue Cross > Information Center > Administrative Support > Network Leasing Arrangements	Contractual issues, allowable charges, etc. - (800) 688-3828 Send Claims to the address on the Member's ID card. For Claims status and eligibility, call the customer service number on the back of the Member's ID card.
Third Party Liability (TPL) Claims	Meridian – (800) 645-9785 **meridianresource.com/subro.html**
Transition Assistance & Second Opinion: Review of Continuity of Care requests for eligible New Enrollees and those effected by Network Disruption.	To initiate requests, call the customer service number on the back of the Member's identification card. (888) 486-4227 Fax: (877) 214-1781 (To fax completed forms)
Utilization Management: A process to ensure the delivery of medically necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner.	Anthem Blue Cross Members (Local Plan): (800) 274-7767 CalPERS: (800) 451-6780 National: (866) 470-6244 Fax for Local Plans, CalPers and National: (866) 815-0839 Specialty Pharmacy (medical benefit): (866) 580-5293 Fax: (866) 408-7195
Workers' Compensation	**AWCCustomerRelations@anthem.com** Medical Provider Network: (866) 700-2168

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/ca** and Select **For Providers** from the horizontal menu, then select **Go To Providers Overview**. On the **Providers Overview page**, and choose content available.

Providers and Facilities can also sign-up for the email communications 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/ca**, select **For Providers, Providers Overview**, then scroll down and select **Read the Most Recent Provider News**. On the ***Provider News*** 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
  - 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
  - Education and Training
  - Contact Us
- Join Our Network
  - Getting Started with Anthem
  - Credentialing
  - Employee Assistance Program (EAP)

Online Provider Directory & Demographic Data Integrity

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

Online Provider Directory

Accessing the Online Provider Directory:

Go to **anthem.com/ca**

Select the **Find Care** link at the top right of the page.

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

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

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

Updating Demographic Data with Anthem

It is critical that Members receive accurate and current data related to provider availability. Providers and Facilities must notify Anthem or any Anthem designee of any demographic changes. Unless a shorter time period is required by the Agreement, including any SB 137 requirements, all requests must be received thirty (30) days **prior** to change/update or such shorter time period required by the Agreement. Any requests received within less than thirty (30) days' notice or such shorter time period, 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

Note:* To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to **anthem.com/ca, select **For Providers**, under the Join our Network heading select the **Getting Started with Anthem** link. Next, select **Begin Application**.

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

Submitting Provider demographic data requests and roster submissions through Roster Automation

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

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

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

The resources for this process are listed below and available on our website. 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 to be verified and update the information. Before selecting the TIN/business name, select the three-bar menu option on the right side of the window, and select **Upload Rosters** and follow the prompts.

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

Exclusions

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

Availity Essentials

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

Availity Essentials is available to all Providers and Facilities:

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

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

- **Eligibility and Benefits application:** Access current Member coverage, benefits information and Member's digital ID cards. Use the Patient Registration tab to access Eligibility and Benefits.
- **Submit Claims:** Use either the Claims & Payments application or EDI gateway.
- **Claims Status application:** Monitor claim status, submit documents, and file claims disputes online. Access Claims Status from the Claims & Payments tab.

- **Authorizations:** Submit for medical or behavioral health inpatient or outpatient services, file appeals and track authorization cases. Access the Authorization from the Patient Registration tab.
- **Provider Data Management:** Update demographic information digitally. Access the Provider Data Management application through the My Providers tab.
- **Roster Automation:** Use standardized forms, identify necessary changes, and update the demographic system seamlessly.
- **Remittance Advice:** View, print, or save a copy of remittance advice through the Claims Status application or through Remittance Inquiry in Payer Spaces
- **Clinical Documentation Lookup Application:** Search our Medical Policies by CPT code to view a list of documents needed to process your Claim.

Additional methods of digital engagement include:

Carelon Medical Benefits Management: Carelon Medical Benefits Management Access link to precertification requests and inquiries for specific services and access the **OptiNet®** survey at providerportal.com.

Medical Attachments: Submit supporting documentation including medical records for initial, pended or denied claims through Availity.com. From the Claims & Payments tab, select Claim Status, submit a claim status inquiry and use the Submit Attachments link from a successful response. Use the Medical Attachments functions to submit an itemized bill electronically through the EDI 275 transaction. For providers registered in Medical Attachments through Availity.com, receive digital notifications about additional documents needed for claims processing through Digital RFAI.

Member Certificate Booklet: View a local plan Member's certificate of coverage online, where available. From Availity.com select the Patient Registration tab to access Eligibility and Benefits. The Certificate of Coverage link will be at the top of the page of a successful eligibility and benefits transaction if available in your Anthem market.

Member eligibility and benefits inquiry: Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co- insurance, co-payment and deductible information for ALL Members, including BlueCard® and FEP®. From Availity.com use the Patient Registration tab to access Eligibility and Benefits Inquiry

Secure Messaging: Claim status is available through the Claims & Payments application. If you have claims questions that require additional clarification, Secure Message may be available. From a successful claim status transaction, select the Secure Messaging link to submit a question on the claim. From Availity.com, go to Payer Spaces, select the payer then use the Resources Tab to access Secure Messaging responses.

Payer Spaces

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

- **Alerts Hub:** Primary Care Providers (PCPs) can receive timely information about their patients including admission, discharge and transfer (ADT) and against medical advice discharge notifications.

- **Authorization Look Up Tool:** Determine if an authorization is needed for a commercial Member for a specific outpatient medical or behavioral health service.
- **Chat with Payer:** When the information is not available through self-service on Availity.com, Providers and Facilities can chat with an online representative about prior authorizations, appeals, Claims, eligibility, benefits and more.
- **Clear Claim Connection:** Research procedure code edits and receive edit rationale.
- **Custom Learning Center:** Access payer-centric educational materials.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Patient360:** A robust picture of a Member's health and treatment history including gaps in care and care reminders.
- **Preference Center:** A resource for Providers and Facilities to share correspondence preferences related to specific transactions, for example, prior authorization decision letters and PCPs patient event notifications.
- **Provider Digital RFAI Progress Dashboard:** For Providers and Facilities enrolled in Medical Attachments and using the Attachments Dashboard to receive digital notifications when additional documentation is needed to process Claims, use this Dashboard to show your organization's attachment performance.
- **Provider Online Reporting:** access proprietary Provider and Facility 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 an imaged copy of the paper Anthem remits up to fifteen (15) months in the past.

Getting Started and Availity Essentials Training

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

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

For more information on navigating in Availity, 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 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 on Availity feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI updates. Any changes made to this information automatically applies to all users associated to the organization and affects only the registration information on the Availity Essentials.

Support

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

1. Log onto **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
- 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
- Services through Carelon Behavioral Health

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

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

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

Section 1: Accepting digital ID cards

As our members transition to digital Member ID cards (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

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

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

- EDI transaction: X12 837 – professional, institutional, and dental Claim submission (version 5010):
  - Anthem supports the industry standard X12 837 transactions for all fee-for-service and encounter billing as mandated per HIPAA.

- 837 Claim batch upload through EDI allows Providers and Facilities to upload a batch/file of Claims (must be in X12 837 standard format).

- EDI transaction: X12 276/277 – Claim status inquiry and response:
  - Anthem supports the industry standard X12 276/277 transaction set for Claim status inquiry and response as mandated by HIPAA.
- Availity Essentials – Claims & Payments application
  - The Claims & Payments application enables Providers and Facilities to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
  - 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.

Eligibility

Introduction

In this section, Anthem discusses the options available for verifying eligibility, including ID cards, online inquiry using Availity, and Interactive Voice Response (IVR). **Note**: Eligibility for BlueCard® Members may not be determined through the use of Availity or the IVR.

Determine benefits, eligibility and utilization review (authorization) requirements prior to initiating treatment or rendering services for a Member. In most cases, Anthem Members have direct access to behavioral health services; however, a Member's plan may require a pre-service authorization and/or concurrent review for outpatient services by Anthem.

Remember to request a new copy of the Member's ID card and verify benefits at the beginning of each calendar year in the event a Member's plan has changed. We recommend verifying benefits and eligibility periodically throughout the calendar year to confirm Member eligibility.

What to Consider When Verifying Eligibility and Benefits

- Eligibility of coverage – Coverage can change throughout the calendar year.
- Coverage and benefits
- Copays and coinsurance
- Deductible amounts (if applicable)
- Third Party Administrators (TPA) - if applicable, call the TPA number specified on the Member's ID card.

- ABA services require preauthorization. Contact Behavioral Health UM toll-free at 1-800-399-2421 before initiating treatment, login to Availity.

Behavioral Health Not Managed by Anthem Blue Cross

Members may have Anthem Blue Cross medical coverage and a different carrier for behavioral health care services (i.e. TPA). Contact the other carrier for further information regarding benefits and eligibility.

Claims Address

Anthem Blue Cross has a single mailing address for Claims. However, in some cases, the Claims address may be different for self-funded employer plans, and "Other Payors". Anthem has Network Leasing Arrangements with a variety of organizations, or "Other Payors". Learn more by logging into Availity, key word search, "Network Leasing Arrangements".

Contacting a Customer Service Representative

If Providers and Facilities are unable to use Availity or IVR to verify eligibility, Providers and Facilities may contact a customer service representative by telephoning the appropriate number below. Providers/Facilities can access most customer service resources from the Provider Care Department (PCD), Anthem virtual call center that simplifies the response systems by acting as a dedicated single point of contact just for Providers.

Refer to the number on the back of the Member ID card

Interactive Voice Response System

Interactive Voice Response (IVR) is an automated computer system that provides "real-time" information on the most current eligibility data for all Anthem Members.

To access the IVR, call the Customer Service toll-free telephone number on the Member's ID card. The IVR is available 24 hours a day, seven days a week.

Be sure to have the Provider or Facility tax identification number and/or National Provider Identification (NPI) number and the Member's nine-digit certificate number ready before dialing the IVR toll-free number.

As stated in the "Introduction" of this section, the IVR is not available for verifying BlueCard Program eligibility. Refer to the BlueCard section of this manual.

After a brief welcome message, the IVR will lead Providers and Facilities through the appropriate steps to obtain eligibility information.

The information available is based on the records at that time. Because of delays in receiving information for Members, employers or others, such information may change retroactively.

Identification (ID) Cards

All Anthem Members are assigned a unique identification number. The Anthem identification number is a nine-digit alphanumeric identifier, with a letter in the fourth position, except for client-assigned identification numbers, which will be multiple alphanumeric combinations. For questions regarding the ID cards, refer to the Member service telephone number on the Member's ID card.

Customized Identification (ID) Cards

Anthem has several customized Member ID cards that do not feature the Anthem logo or any Anthem affiliate's logo. Because of contracting arrangements with some Large Group employer groups, the employer's logo appears on the Member ID card. To identify Members with these ID cards, Contact the Member Service phone number on the back of the Member ID cards.

When a Member in one of these product plans requests services, do not deny services or request payment up front. Under the terms of the Agreement, these Members should be treated as Members by Anthem Providers.

Web-Based Identification (ID) Cards

Members who have not yet received their ID cards can print ID cards online through the website at **anthem.com/ca** and present them when seeking health care. New Members seeking medical attention should be asked for their ID card to verify that the Member is seeking care at his or her chosen medical group

Mobile Health Care Identification (ID) Cards

To provide increased convenience, Anthem Members can provide their ID card through a traditional hard copy printed version, Web-based ID card version, or through the *Anthem BC Anywhere* app on a phone or mobile device. Through the app, the card will look and works just like a printed one. Members can show, email or Fax their ID card to Providers. The mobile ID card includes the Member's ID number, copays, Anthem phone number and address, and all other information on the printed version.

Managed Care Services– Third Party Administrators

Managed Care Services (MCS) is the collaboration between Anthem and approved Third Party Administrators (TPA) to deliver access to the Anthem PPO network to self-funded clients. Eligibility for MCS is handled at the TPA. All verification of eligibility, benefits and Claims inquiries must go through the TPA. Refer to the back of the Member ID card for the customer service numbers to call.

Joint Administrative Agreement – Third Party Administrators

Joint Administrative Agreement (JAA) is the collaboration between Anthem and approved Third Party Administrators (TPA) to deliver access to the Anthem network to self-funded clients. Providers can electronically access eligibility, benefits, Claim status and benefit accumulator information via Anthem web portals as well as BlueXChange.

Newborns

Newborn services, including hospital benefits for routine nursery care, screening for genetic diseases, congenital conditions and other health conditions provided, or through a program established by law or regulation, periodic checkups, and immunizations, are covered for the first thirty-one (31) days of life under the health care plans of the parents. After the first thirty-one (31) days, benefits are provided only if the newborn is properly enrolled. While the mother is in the hospital following the birth of the newborn, the cost for the services for the newborn are covered under the mother's bill. If the newborn remains in the hospital after the mother is discharged or is otherwise confined in a non-routine nursery accommodation, a separate account will be opened for the newborn's hospital services.

Newborns of eligible dependent children are not covered.

Pediatric office visits are subject to the same scheduled copayments as regular office visits. Well Baby and Well Child care are Covered Services subject to any scheduled copayments.

Domestic Partners

A domestic partner must meet the Plan's eligibility requirements for domestic partners as outlined in the Member's Evidence of Coverage (EOC) or certificate.

For questions regarding whether this coverage is applicable to a specific employer group, refer to the number on the back of the Member ID card.

Rescission Investigation – Anthem Blue Cross Individual Members

If during the first two (2) years of the effective date of coverage, Anthem Blue Cross discovers that an Individual Member performed or engaged in any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact that was not disclosed on the application, Anthem Blue Cross may rescind the individual's coverage as if it never existed back to the original effective date. Additionally, if within two (2) years after adding additional dependents (excluding eligible newborn children added within sixty (60) days after birth), Anthem Blue Cross discovers any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material facts that the Individual Member or their dependent knew, but did not disclose in their application, Anthem Blue Cross may rescind coverage for the additional dependent as of the date he or she originally became effective.

Anthem Blue Cross does not complete the processing of any submitted Claims until we complete the investigation. All eligible benefits are to be provided to the Member for as long as an Anthem Blue Cross contract is in force. Services cannot be delayed or denied while a Member is undergoing investigation for possible rescission. Benefits for services can only be denied once a contract is rescinded by Anthem Blue Cross.

If a Member's contract is rescinded, the PPO Provider may bill the individual for all outstanding Claims for services provided.

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.

Credentialing

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

Anthem's Credentialing Program also includes the recredentialing process which incorporates re-verification and the identification of changes in the practitioner's or HDO's credentials that may reflect on the practitioner's or HDO's professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards. All applicable practitioners and HDOs in Anthem's network within the scope of the Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by applicable state contract or state regulations. Additional information regarding Anthem's Credentialing Program can be found in the Program Summary, which applicable terms are incorporated into this Provider Manual by reference," available on **anthem.com/ca**. Select For **Providers** and then **Credentialing** under **Join Our Network**, **Select** the **Program Summary** under the question, **Who do we Credential.**

Standards of Participation

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

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification/State Licensure
Ambulatory Event Monitoring	Medicare Certification

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

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

Anthem Designated Medical Specialty Pharmacy

CVS Specialty Pharmacy is the Anthem Blue Cross (Anthem) designated provider of certain specialty medications administered in the office or outpatient hospital setting. For dates of service on or after December 1, 2020, for patients with Anthem commercial PPO or EPO plans, Providers will be required to work with CVS Specialty to procure certain drugs that are covered through a Member's medical benefit. CVS Specialty provides timely fulfillment and distribution to meet the needs of Providers and Members.

Providers impacted by this requirement have been previously notified separately and only applies to those specific Providers.

CVS Specialty will ship specialty drugs to Provider's office, hospital or location of the Provider's choice. Providers should continue to submit for administration of the medication, but bill a zero charge for the medication itself. CVS Specialty will bill Anthem for the medication, and Anthem will pay them directly.

The link below provides the current CVS drug list associated with the Anthem HMO / PPO Specialty Drug initiative. All drugs on this list must be procured by the ordering provider through CVS unless they have been exempted by Anthem: **anthem.com/docs/public/inline/MSP_Drug_List.pdf**

IMPORTANT: If certain specialty medications are obtained through other pharmacies, the Claim will be denied.

CVS Specialty's Dedicated Anthem Team
Phone: 877-254-0015
Fax: 866-336-8479
Hours of Operation: Mon.-Fri. 5:00 am – 7:30 pm PT; Sat. 6:00 am – 10:00 am PT

If Providers have questions, or would like to learn the terms of participating in the specialty drug network, contact an Anthem contract manager, or the Provider Experience team on the *Contact Us* page on **anthem.com/ca** for self-service tools and up-to-date contact information: **anthem.com/ca/provider/contact-us/**

Claims Submission

Electronic Claims Submissions

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

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

Reference the Transaction Specific Companion Documents available on the EDI webpage. Go to **anthem.com/ca/provider/edi**/. Scroll to **Companion Guide**, Select **Review the Guide**, then see the appropriate link under the *Section B: Transaction-specific Documents* heading.

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

Claim Submission Filing Tips

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

Ambulatory Surgical Centers

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

Ancillary Filing Guidelines

Ambulance Claims

Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.

- Ground or Independently contracted ambulance Providers should fFile the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- Air Ambulance providers contracted through a facility should file claims to the Plan whose service area matches the facility (local Plan).

The POP (Point of Pick-up) ZIP Code should be submitted as follows:

- Professional Claims – for CMS-1500 submitters: the POP ZIP code is reported in field 23 or 54
- Institutional outpatient Claims – for UB submitters: the Value Code of 'A0' (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

Durable/Home Medical Equipment and Supplies

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

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

Home Infusion Therapy – Services and Supplies

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

Independent Clinical Laboratory Claims

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

Independent lab Claims are determined by the place of service code 81.

Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:

- ASC X12 837 professional Claim format REF segment as REF02, with qualifier of "X4" in REF01 or
- Field 23 of the paper CMS-1500

Specialty Pharmacy Claims

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

Anthem Rate requiring billing of specific DX code(s)

For any Anthem Rate that requires Facility to bill a particular diagnosis code to receive that Rate, as set forth in the Agreement with Anthem, Facility shall bill the required diagnosis code on the Claim form in the first position in the field locator where the primary diagnosis code is to be specified. If on the Claim form multiple diagnosis codes are billed, each of which trigger different Anthem Rates, Facility shall receive only that Anthem Rate that is triggered by the diagnosis code billed in the first position on the field locator on the Claim form.

Blue Distinction Centers of Transplant (BDCT) / Centers of Medical Excellence (CME)

See the information at **Learn more about the Blue Distinction Program**.

Claim Editing and Reimbursement Policy Application

Anthem uses Member benefits, Health Plan reimbursement policies, and a Claims editing software in its adjudication of Claims.

Claim Receipt Verification

To verify receipt of a Claim, log in to Availity at **availity.com.** For more information on Availity see Section titled **Availity Essentials (Availity).** Contact Anthem by plan type at the customer service telephone number listed on the back of the Member's ID card. The Explanation of Benefits (EOB) or Remittance Advice (RA) will verify receipt of a Claim, as well.

CPT Coding

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

Duplicate Claims

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

Late Charges

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

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

Midnight/24- or 48-hour rule

Certain Facilities have an Agreement with Anthem that requires the application of the Midnight or 24-/48- hour rule to Members who are outpatients. If the Agreement contains one of those rules, subject to the five (5) exceptions below, the following applies – for all Members that occupy a bed as of midnight or, depending upon the terms of the Agreement with Anthem, for more than 24/48 hours, even if not admitted as an inpatient, the Anthem Rate will be the lesser of Facility's Eligible Billed Charges or the Inpatient General Acute Per Diem Rate as specified in the Agreement with Anthem. If the Agreement with Anthem does not include the Midnight or 24-/48-hour rule, then this specific

paragraph and the remainder of this Section below does not apply. In this circumstance, inpatient Claims will be paid in accordance with inpatient reimbursement rates and outpatient Claims will be paid in accordance with outpatient reimbursement rates regardless of how long the Member remains in the Facility as an outpatient.

Exceptions to the above reimbursement methodology (meaning the applicable outpatient rate will always apply) are as follows:

i. Outpatient Emergency Services (no surgical procedure). Reimbursement will be the Anthem Rate for Outpatient Emergency Services, until such time as Member is admitted as an inpatient or is discharged from Facility, regardless of the duration of the Outpatient Service and no matter where in the Facility the Member is discharged from. If the Member is admitted as an inpatient following an Emergency Department Visit, the services rendered in connection with the emergency condition are inclusive to the applicable inpatient Anthem Rate and the applicable inpatient reimbursement shall begin on the date that the Member is first admitted as an inpatient;

ii. Outpatient Emergency Services (surgical procedure with no operating room, recovery room, treatment room or observation room Revenue Codes reported). Reimbursement will be the Anthem Rate for Outpatient Emergency Services, until such time as Member is admitted as an inpatient or is discharged from Facility, regardless of the duration of the Outpatient Service, and no matter where in the Facility the Member is discharged from;

iii. Outpatient Therapy Services. Reimbursement will be the applicable Anthem Rate for outpatient therapy services, until such time as Member is admitted as an inpatient or is discharged from Facility, regardless of the duration of the Outpatient Service, and no matter where in the Facility the Member is discharged from;

iv. Outpatient Infusion Therapy Services. Reimbursement will be the applicable Anthem Rate for outpatient infusion therapy services, until such time as Member is admitted as an inpatient or is discharged from Facility, regardless of the duration of the Outpatient Service; and no matter where in the Facility the Member is discharged from.

v. Emergency Room with Observation Carve-Out Rate. Some Hospitals have negotiated a specific outpatient carve-out rate that reimburses the Hospital for outpatient emergency room services with observation services, even if the Member stays past midnight or more than 24 hours. If the Agreement with Anthem contains this provision, the Midnight/24-hour rule does not apply. Reimbursement shall be at the ER with Observation carve-out rate, regardless of the duration of the outpatient stay.

In lieu of using a midnight rule, some Facility Agreements define a day of service as a stay exceeding 24 or 48 hours. Therefore, the same rules described above will still be applied, except that a day of service occurs after a patient occupies a bed for 24 or 48 hours instead of when the patient occupies a bed as of midnight. Subject to the exceptions above, a day of service is reimbursed at the lesser of the Facility's Eligible Billed Charges or the inpatient Per Diem rate.

Providers shall provide admission and discharge time information when submitting Claims for Facility-based charges, as this information is needed to determine if a day of service has occurred.

Maternity Delivery Claims

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

National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

Negative Charges

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

Non-Member Transplant Donor Claim

Use the Non-Member Transplant Donor Form when submitting non-Member donor Claims. Check the box referenced under reconsideration of a return and/or rejected Claim. Attach the Claim to this form and mail to Anthem Blue Cross. This will help expedite the processing.

Not Otherwise Classified (NOC) Codes

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

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

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

Occurrence Dates

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

Other Insurance Coverage

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

CMS-1500 Fields:

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

UB-04 CMS-1450 Fields:

- Field 50a-c: Payer Name
- Field 54a-c: Prior payments (if applicable)

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

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

Preventive Colonoscopy – correct coding

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

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

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

Split-year Claims

For services that begin before or during December of one year, but extend into or beyond January of the following year, split the Claims at the calendar year's end. This is necessary to accurately track calendar-year deductibles and copayment maximums.

Type of Billing Codes

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

Claim Inquiry/Adjustment Filing Tips

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

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

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

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

Claim Payment Disputes: Refer to the Provider and Facility Dispute Resolution 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 in 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/predetermination requests or appeals to the provider correspondence address may delay responses.

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

Proof of Timely Filing

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

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

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

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

Acceptable documentation includes the following:

1. A copy of the Claim with a **computer-printed filing date** (a handwritten date isn't acceptable)

1. 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
2. The Provider or Facility's billing system printout showing the following information: date of service, amount billed, Member name, original date filed with Anthem and description of the service
3. If the Provider or Facility doesn't have an electronic billing system, approved documentation is a copy of the Member's chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.
4. If the Claim was originally filed electronically, a copy of Anthem's electronic Level 2 or the respective clearinghouse's acceptance/rejection Claims report is required; a copy can be obtained from the Provider or Facility's EDI vendor, EDI representative or clearinghouse representative. The Provider or Facility also must demonstrate that the Claim and the Member's name are on the original acceptance/rejection report. *Note:* When referencing the acceptance/reject report, the Claim must show as accepted to qualify for proof of timely filing. Any rejected Claims must be corrected and resubmitted within the timely filing period.
5. A copy of the Anthem letter requesting additional Claim information showing the date information was requested.

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

Corrected Claim Guidance

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

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

Type	Professional Claim	Institutional Claim
EDI	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In Segment "REF – Payer Claim Control Number"	**To confirm the Claim which is being replaced:** • In Segment "REF – Payer Claim Control Number"

Type	Professional Claim	Institutional Claim
	• Use F8 in REF01 and list the original payer Claim number is REF02	• Use F8 in REF01 and list the original payer Claim number is REF02
	To indicate the Claim was billed in error (Void/Cancel): • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8	**To indicate the Claim was billed in error (Void/Cancel):** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02	**To confirm the Claim which is being void/cancelled:** • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02
Digital	Submit replacement, void/cancel claims through **Availity.com**	Submit replacement, void/cancel claims through **Availity.com**
	Select the **Claims & Payments tab** and click **Professional Claim**	Select the **Claims & Payments tab** and click **Facility Claim**
	Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information** • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.	Enter the clam information and set the billing frequency and payer control number as follows: • Select **Replacement of Prior Claim** or **Void/Cancel of Prior Claim** for the **Billing Frequency** (or **Frequency Type**) field, in the **Claim Information** • Set the **Payer Control Number (ICN / DCN)** (or **Payer Claim Control Number**) field to the claim number assigned to the claim by the payer. You can obtain this number from the 835, if available.
Paper	**To indicate the Claim is a replacement Claim:** • In Item Number 22: "Resubmission and/or Original Reference Number" • Use Claim Frequency Type 7 under "Resubmission Code"	**To indicate the Claim is a replacement Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the resubmitted Claim.	**To confirm the Claim which is being replaced:** • In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: • In Item Number 22: "Resubmission and/or Original Reference Number"	**To indicate the Claim is a void/cancel of a prior Claim:** • In Form Locator 04: "Type of Bill" • Use Claim Frequency Type 8

Type	Professional Claim	Institutional Claim
	• Use Claim Frequency Type 8 under "Resubmission Code"	
	To confirm the Claim which is being void/cancelled: • In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer Claim number for the void/cancelled Claim.	**To confirm the Claim which is being void/cancelled:** • In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.

For additional information on provider disputes and appeals, refer to the Provider and Facility Dispute Resolution sections of this Manual.

National Drug Codes (NDC)

All Providers and Facilities are required to supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 Claim forms as well as on the 837 electronic transactions, except when administered in an inpatient setting. *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 **will deny if** Healthcare Common Procedure Coding System (HCPCS) codes or Current Procedural Terminology (CPT) codes, for drugs administered in a physician office or outpatient facility setting **AND** do not include the following:

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

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

The above requirement is in addition to the requirement for an NDC code on NOC Claims discussed earlier in this Claims Submission section.

Unit of Measurement Requirements

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

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

- ME – Milligram

Location of the NDC

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

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

Correcting Omission of a Leading Zero

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

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

If the NDC appears as…	Then the NDC…	And it is reported as …
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	**0**1234123**0**1
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345**0**12312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	1234512340

Process for Multiple NDC numbers for Single HCPC Codes

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

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

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

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

How/Where to Place the NDC on a Claim Form

837 Reporting Fields

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

Loop	Segment	Element Name	Information	Sample
2410	**LIN02**	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**__**N4**__*01234567891~
2410	**LIN03**	Product or Service ID	Enter the NDC	LIN**__N4*__**01234567891**__~
2410	**CTP04**	Quantity	Enter quantity billed	CTP****__**2**__*UN~
2410	**CTP05-1**	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit GR: Gram ML: Milliliter UN: Unit ME: Milligram	CTP****2*__**UN**__~
2410	**REF01**	Reference ID Qualifier (used to report Prescription # **or** Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ: Prescription Number	REF01*__**XZ**__*123456~
2410	**REF02**	Reference Identification	Prescription Number **or** Link Sequence Number	REF01*XZ*__**123456**__~

Digital submission through Availity.com:

- From Availity.com select the Claims & Payments tab then select Professional Claim or Facility Claim.

- Enter the NDC code in the NDC Code field that is associated with the procedure code/service line.
- In the NDC Quantity field, you can enter a maximum of 13 numbers before the decimal point and a maximum of two numbers after the decimal point.
- Convert the NDC to 11-digits following the instructions noted above.

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

CMS 1500 Claim Form:

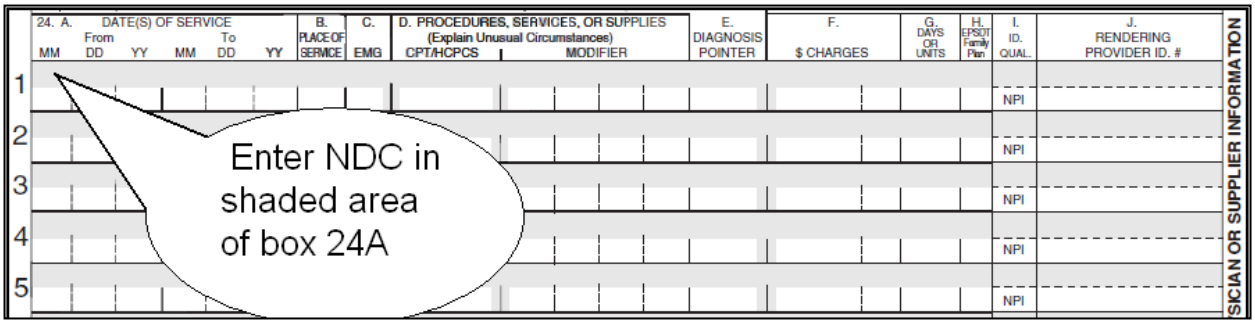
- Reporting the NDC requires using the upper **and** lower rows on a Claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- DO NOT bill more than one NDC per Claim line.
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered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

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

All Elements are REQUIRED:

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

UB04 Claim Form:



Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the Claim form.

If the NDC billed does not have a specific HCPCS or CPT code assigned, the appropriate miscellaneous code should be assigned per Correct Coding Guidelines.

DO NOT bill more than one NDC per Claim line.

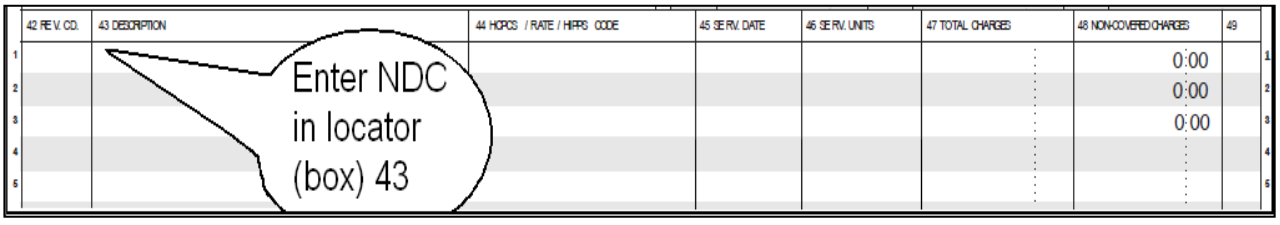
The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

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

All Elements are REQUIRED:

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11- digit NDC, including the N4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC In locator (box) 43 currently labeled as “Description”
Enter a valid HCPCS or CPT code • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Units • ME – Milligrams and quantity, including **a decimal point for correct reporting**	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter three (3) spaces followed by one (1) of five (5) units of measure qualifiers, followed immediately by the quantity.
Enter a valid HCPCS or CPT Code	J0610 “injection Calcium, per 10ML” is billed as one (1) unit for each 10ML ampul used	Form locator (box 44)

Sample Images of the UB04 Claim Form



42 REV. CD.	43 DESCRIPTION	44 HCPCS / RATE / HIPPS CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGES	48 NON-COVERED CHARGES	49
####	N 4########## GR0.045	J####	MMDDYY	1	## :##	0:00	

Paper Claims Submissions

Digital claim submission, either through the claim submission applications on Availity.com or through EDI, are the preferred method for receiving claims. Filing paper claims can cause delays due to errors associated with using this manual claim submission process. If Providers or Facilities file a paper Claim, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause Claims to be rejected and returned to the Provider or Facility. More information and the most current forms can be found at **cms.gov**.

- Submit all paper Claims using the current standard RED CMS Form 1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid Member identification number including three-digit prefix or R+8 numeric for Federal Employee Program® (FEP®) members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

CMS Form 1500 (02-12)

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

UB-04 (CMS-1450)

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

Hospital Stop Loss Billing Instructions

This section provides the specific billing submission requirements that will assist Facilities with the submission process for Stop Loss reimbursement under the Agreement. It also identifies the more common situations that result in returned or rejected Claims and processing delays due to returned or rejected Claims.

Throughout this section Anthem uses the term “Total Eligible Billed Charges.” This means the Facility’s billed charges for Covered Services, except for those charges that are identified as disallowed charges in the Agreement with Anthem or in the Provider Manual (Disallowed Charges). Disallowed Charges are not eligible for reimbursement.

Hospital Stop Loss Billing Requirements

The following are the billing requirements for the submission of Hospital Stop Loss Claims to Anthem. For a Claim to be considered for Hospital Stop Loss reimbursement, it must meet specific threshold requirements. For the exact threshold and calculation methodology, refer to the Agreement. Specific billing requirements are as follows:

Billing Requirements – Anthem's Hospital Stop Loss billing requirements apply to all Anthem Member inpatient Claims submitted for payment under the Stop Loss provision of the Agreement.

Type of Bill Code – All Claims must have the appropriate Type of Bill Code. The three-digit type of bill code provides the appropriate Facility type, billing classification and frequency information. Note: Claims submitted with incorrect or inappropriate bill types will either delay the Stop Loss payment or result in an incorrect

- Type 111 – A completed Claim, from admit to discharge, should be coded as a Type 111.
- Type 112 – Continuing interim Claims submitted to the Hospital Stop Loss Processing Unit, regardless of the Total Eligible Billed Charges, will be rejected for complete and final Claim. Only the per diem payment will be processed on Type 112 billing.
- Type 114 – Final interim Claims submitted to the Hospital Stop Loss Processing Unit, regardless of the Total Eligible Billed Charges, will be rejected for complete and final Claims. Only the per diem payment will be processed on Type 114 billing.
- Type 115 – Late charge only.
- Type 117 – Revised/Replacement Claims: These Claims should be used when the Claim is revised, as opposed to submitting a revised Type 111 bill.

Status Codes – The Status Code of the Claim must indicate that the Member has been discharged or transferred (see *UB-04* Data Specification Manual formally known as *UB-04* Billing Guidelines Manual) to be eligible for the Stop Loss provision. If the Member is still hospitalized, the bill will be processed as an interim Claim, and will not be considered under the Hospital Stop Loss provision until the Member has been discharged and the complete and final Claim is submitted to Anthem Blue Cross at either of the addresses listed in the next subsection, "Where to Submit for Stop Loss Reimbursement. "Itemized Bill – For a bill to be considered for Stop Loss reimbursement, it must include both the UB-04 Claim and an itemized statement for the Member's entire admission at the Facility.

Where to Submit for Hospital Stop Loss Reimbursement

Anthem does not require that the Facility submit a separate Stop Loss Claim in addition to any other Claim that the Facility may submit for any one inpatient stay by a Member. However, all Stop Loss Claims should be clearly identified as such. The address for the submission of Hospital Stop Loss Claims and Hospital Stop Loss Claim-related correspondence can be to either of the following addresses:

Anthem Blue Cross
Attn: Hospital Stop Loss Processing Unit
P.O. Box 60007
Los Angeles, California 90060-0007

OR

Anthem Blue Cross
Attn: Hospital Stop Loss Processing
21215 Burbank Blvd
Woodland Hills, CA 91367

Hospital Stop Loss Inquiry Customer Service Number Discontinued

Institutional stop loss inquiries should be directed to the number located on the back of the Member's ID card. If Facilities do not have a copy of the Member's ID card, call the phone number 1-800-676-2583 to be transferred to the appropriate customer service department.

For California contracting inquiries, visit the *Contact Us* page on **anthem.com/ca** for self-service tools and up-to-date contact information: **anthem.com/ca/provider/contact-us**

Hospital Stop Loss Claim Submission Filing Limits

Facilities must submit Hospital Stop Loss Claims to Anthem at either of the addresses shown above within the amount of time specified in their Agreement. The filing limit also applies to adjustments and/or corrected Claims. For Hospital Stop Loss Claims that involve coordinating benefits with another carrier or Medicare, the date of the other carrier's Explanation of Benefits or Medicare's Explanation of Benefits is the date upon which the Hospital's Claim submission time period shall begin.

If the Claim is submitted after the filing period, it is not eligible. The patient is not responsible for this amount. If a Hospital believes a rejected Hospital Stop Loss Claim was submitted within the filing deadline set forth in the Agreement, acceptable evidence of timely filing (in one of the forms described in this Manual) must be attached to the Anthem Hospital Stop Loss rejection letter or denial Explanation of Benefits from the other carrier and should be submitted to Anthem in a timely manner for consideration. **Do Not Resubmit A Copy Of The Original Bill.**

Hospital Stop Loss Disallowed Charges

Only Total Eligible Billed Charges for Covered Services will be considered for determining whether Facility has met its Stop Loss threshold. Additionally, the only Total Eligible Billed Charges for Covered Services that are eligible for Stop Loss reimbursement are basic room-and-board charges. The following charges, and any similar or related charges, are Disallowed Charges and are excluded from Hospital Stop Loss consideration, whether billed under the indicated Revenue Codes or any other Revenue Code. The Disallowed Charges (which are not eligible for reimbursement) include, but are not limited to, the following:

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
0990 – 0999	**Personal Care Items** • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Stand-by Charges
0220, 0949	Add on Stat Charges
0270 – 0279, 0360	Video Equipment Used in Procedures
0270, 0271, 0272	**Supplies and Equipment** • Blood Pressure cuffs/Stethoscopes • Thermometers, Temperature Probes, etc. • Pacing Cables/Wires/Probes • Pressure/Pump Transducers • Transducer Kits/Packs • SCD Sleeves/Compression Sleeves/Ted Hose • Oximeter Sensors/Probes/Covers • Electrodes, Electrode Cables/Wires • Oral swabs/toothettes • Wipes (baby, cleansing, etc.) • Bedpans/Urinals • Bed Scales/Alarms • Specialty Beds • Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls • Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment/Supplies (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.)
0220 – 0222, 0229, 0250	**Tech Support Charges** • Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy: • IV Infusion concurrent for therapy (96368); • IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	**Other Charges** • Observations hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator • Respiratory assessment/vent management charges
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	**Pharmacy** • Compounding fees • Medication prep • Nonspecific descriptions

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Anesthesia Gases – Billed in conjunction with Anesthesia Charges • IV Solutions 250 cc or less • Miscellaneous Descriptions • Non-FDA Approved Medications (subject to UM determination- Medical Policies)
0256	Experimental Drugs (subject to UM determination- Medical Policies)
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	**Venipuncture** (CPT Code 36415, 36416 or G0001) • Specimen collection • Draw fees • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling/Splitting, etc.
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	**Supplies and Equipment** (including rentals) • Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and/or the room and board • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies When Billed with Anesthesia Charges

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump and supplies • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • DaVinci Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	**Anesthesia** (specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Pre- or Post-evaluation and education • IV sedation and local anesthesia by same physician or procedure nurse • Intubation/Extubation • CPR
410	**Nursing/Respiratory Functions:** • Oximetry (94760, 94761, 94762) • Vent Management • Postural Drainage • Suctioning Procedure • Nursing/Respiratory care performed while patient is on vent
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges
0940 – 0945	Education/Training
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
0110 – 0119	Private Room*
0990	Patient Convenience Items
0991	Cafeteria, Guest Tray

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

* Subject to the Member's Benefit Agreement.

Common Reasons for Rejected and Returned Hospital Stop Loss Claims

Many of the Claims rejected result from common mistakes in billing entries. The following is a list of some of the more typical reasons why a Hospital Stop Loss Claim is rejected:

Filing Limits

- The Hospital Stop Loss Claim-filing deadline is specified in the Agreement and is the number of calendar days after the patient was discharged. All Hospital Stop Loss Claims must be submitted to Anthem within that deadline. If not, the Stop Loss Claim will be rejected as untimely. This time limit also applies to late charges and corrected Claims.

Unable to Identify Member

- For Members of Other Blue Plans (BlueCard®): The main identifier for out-of-area Members is the alpha prefix. The three-character alpha prefix at the beginning of the Member's identification number is the key element used to identify and correctly route Claims. The alpha prefix identifies the Blue Plan or National Accounts to which the Members belongs. It is critical for confirming a patient's Membership and coverage.
- For Federal Employees Program (FEP), the alpha prefix is omitted in addition to other numeric digits. The FEP ID number starts with an alpha "R" and is followed by eight numeric digits. Supply the nine-digit ID number for all FEP submissions.
- Members of Anthem affiliates using a California Hospital: The affiliate's name must be clearly indicated, along with the ID number of the Member.

Total Eligible Billed Charges do not exceed Hospital Stop Loss Dollar Threshold – The Total Eligible Billed Charges may not meet the Hospital Stop Loss threshold, based on the Agreement's specifications. Refer to the list below:

- Total Eligible Billed Charges are below the dollar threshold amount; or
- Removal of noneligible or disallowed charges caused the Total Eligible Billed Charges to fall below the threshold; or

- Removal of non-covered day charges caused the Total Eligible Billed Charges to fall below the threshold; or
- Total Eligible Billed Charges are less than the per diem threshold.

Federal Employee Claims subject to OBRA pricing and Centers of Medical Excellence (CME) Rates – The Hospital Stop Loss provision may not apply when other rates are applied to the bill. Check the specific Agreement for Stop Loss Disallowed Charges.

Utilization Management Approval – Hospital Stop Loss is only payable for the days approved as Medically Necessary. If the stay is not approved, the bill will not have the Hospital Stop Loss provision applied. In addition, if a portion of the stay is not approved as Medically Necessary and therefore, the total Eligible Billed Charges are below the threshold, the bill is not eligible for Stop Loss reimbursement.

Anthem Blue Cross Not The Primary Payor – Hospital Stop Loss provision is only applicable to Claims for which Anthem is the primary payor.

Researching a Hospital Stop Loss Claim

Claim status inquiry is available through Availity. Login to **availity.com.** From the top of the page, select the **Claims** tab and choose **Claims Status Inquiry** from the drop-down menu. For questions about a Claim, refer to the **Secure Messaging – Availity** subsection below and find out how.

If Providers ad Facilities cannot access the website, the following information may be helpful in researching a Claim:

Was the Claim electronically submitted?

At the present time, electronically submitted Claims are not priced under the Hospital Stop Loss provision. To be eligible for the Hospital Stop Loss provision, the complete and final Claim, including an itemization, should be submitted via paper copy to either of the addresses listed below:

Anthem Blue Cross
Attn: Hospital Stop Loss Processing Unit
P.O. Box 60007
Los Angeles, California 90060-0007

OR

Anthem Blue Cross
Attn: Hospital Stop Loss Unit
21215 Burbank Blvd
Woodland Hills, CA 91367

Was the Claim eligible for the Hospital Stop Loss Provision?

The Hospital Stop Loss provision only applies to inpatient stays at California Hospitals that meet certain contracted requirements. Verify that the Hospital Stop Loss provision applies to the stay submitted.

Questions regarding the *UB-04* Data Specification Manual or a specific Hospital Stop Loss bill can be addressed to the Hospital Stop Loss Processing Unit at the address below:

Anthem Blue Cross
Attn: Hospital Stop Loss Unit
21215 Burbank Blvd
Woodland Hills, CA 91367

Medical Records Submission

When submitting documentation in response to Anthem's request, the recommended method is to submit them electronically via the 275 transaction or digitally through the Attachments Dashboard. To attach requested documentation, navigate to Availity Essentials Claim Status, locate your claim and use the Send Attachment link to upload your documents. The Medical Attachments tool supports .tiff, .jpg and .pdf attachment file types. Providers and Facilities should submit medical records within ten calendar days of Anthem's request, or sooner depending upon the urgency of the matter and or as required by state or federal law, statute or regulation. Providers and Facilities can view the status of submitted documentation in Availity Essentials Attachment New.

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

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

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

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

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

Medical Records Submission with Initial Claim

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

To determine what medical records or portion of the medical records may be required, refer to the applicable Anthem Medical Policy, Anthem Clinical Guideline, Carelon Clinical Guidelines or MCG at **anthem.com.**

Review the Position Statement section of the Anthem Medical Policies, or Clinical Indications section in the applicable Anthem or Carelon Clinical Guidelines to determine what medical records are needed. Refer to the *Medical Policies*, *Clinical Guidelines*, and/or *Carelon Medical Benefits Management* sections of the Provider Manual for details on accessing this information.

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

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

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

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

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

Digital Request for Additional Information

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

Digital RFAI notifications reduce the amount of time it takes for Anthem to receive needed documentation to process your Claims. This reduces Claims processing time and Claims are paid faster.

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

Types of Claims Documentation Required

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

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

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

Medical Record Appeals

When a request additional for information is received in support of the resolution of a grievance or appeal, the Providers and Facilities 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).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 Availity Essentials. 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)
- Or use the Provider or Facility's existing clearinghouse or billing vendor. Requires the vendor to have a connection to the Availity EDI Gateway.

Electronic Data Interchange Trading Partner

Trading partners connect with Availity's EDI gateway to send and receive EDI transmissions. 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 **Availity.com.**

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

EDI Response Reports

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

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

Electronic Funds Transfer (EFT)

Electronic claims payment through electronic funds transfer (EFT) is a safe, secure and fast way to receive payment. There is no charge for the deposit and EFT reduces administrative time related to posting and reconciling payments. EFT 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/ca. Select For Providers from the top horizontal menu, select Electronic Data Interchange (EDI) under Claims. Next, once on the EDI page scroll to the bottom section EDI Resources and select the Electronic Funds Transfer tab.

Virtual Credit Cards (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 cards (VCCs). VCCs allow Providers and Facilities to process payments as credit card transactions. Check with your merchant processor regarding standard transaction fees that will apply. For detailed information, refer to the *Provider and Facility Digital Guidelines* section of this Manual.

Electronic Remittance Advice (ERA) 835

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

Use Availity Essentials to register and manage ERA account changes:

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

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

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

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.
- **Availity Essentials Registration Page** – Availity Essentials registration page for users new to Availity.
- **X12 External Code Listing** – X12 code descriptions used on EDI transactions.

Overpayments

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

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

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

Anthem Identified Overpayment (aka "Solicited")

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

- The payment coupon
- Member ID number
- Member's name

- Claim number
- Date of service
- Reason for the refund as indicated in the refund request letter

As indicated in the Anthem refund request letter and in accordance with Provider contractual language, and state regulations, Provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment from any Claim 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 of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below

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

- *Provider Refund Adjustment Request (PRAR) Form*
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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

Utilize the correct address noted below to return payment:

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

Overpayment Recovery Procedure

Anthem seeks recovery of all excess Claim payments from the payee to whom the benefit check is made payable.

The procedure for overpayment recovery is set forth below:

1. **Day 1:** Anthem identifies overpayment.
2. **Day 3:** Overpayment recovery letter is sent to the Provider

   If the Provider or Facility believes that the overpayment was created in error, the Provider or Facility should contact Anthem in writing pursuant to the instruction in the overpayment letter.

   If Anthem does not hear from the Provider or Facility, or receive payment within 45 days, the following action is taken:
3. **Day 45:** Anthem will deduct overpayment amounts from future Claim payments.
4. **Day 120:** If a check for the overpayment has not been received or Anthem has been unable to recover the overpayment amount or Provider or Facility has not contested the overpayment amount, Provider or Facility is referred to a collection service.

Note: These are calendar days, not business days.

For any questions regarding overpayment recovery, refer to the **Directory of Services** for the appropriate telephone number for Financial Operations under "Financial Operations: Overpayment Recovery.*

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 payer to eliminate the need for Provider or Facilities or their billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

When a Medicare Claim has crossed over, Providers and Facilities must wait thirty (30) calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Member's Blue Plan.

To avoid the 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 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

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

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

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

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

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

Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.

Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)

The Provider or outpatient Facility's local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

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

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

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

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

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

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

Medicare Crossover Claims FAQs

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

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

   - If the remittance advice indicates that the Claim was crossed over, Medicare has forwarded the Claim on behalf of the Provider or Facility to the appropriate Blue Plan and the Claim is in process. ***DO NOT*** resubmit that Claim to Anthem; duplicate Claims will result in processing and payment delays.
   - If the remittance advice indicates that the Claim was not crossed over, submit the Claim to the local Anthem Plan with the Medicare remittance advice.
   - In some cases, the Member identification card may contain a COBA ID number. If so, be certain to include that number on the Claim.

- For Claim status inquiries, contact the local Anthem Plan.

3. **Who do Providers and Facilities contact with Claims questions?**

   The local Anthem Plan.

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

   - If Members contact a Provider or Facility, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
   - A Member's Blue Plan should not contact Providers or Facilities directly, unless a paper Claim was filed directly with that Blue Plan. If the Member's Blue Plan contacts the Provider or Facility to send another copy of the Member's Claim, refer the Blue Plan to the local Anthem Plan.

5. **Where can Providers and Facilities find more information?**

Visit Anthem's website at **anthem.com/ca** or contact the local Anthem Plan.

Provider and Facility Dispute Resolution

The Department of Managed Health Care (DMHC) promulgated regulations known as the Claims Settlement Practices and Dispute Resolution Mechanism Regulations (Claims and Dispute Regulations), which can be found in Title 28 of the California Code of Regulations, Sections 1300.71 and 1300.71.38. These regulations require that Anthem and its Providers and Facilities establish a fast, fair, and cost-effective dispute resolution mechanism to process and resolve disputes for Providers and Facilities and non-participating providers and facilities.

To the extent required by the Claims and Dispute Regulations, the following sets forth Provider and Facility rights, responsibilities and the related procedures for filing a Provider or Facility dispute with Anthem. Unless otherwise provided herein, capitalized terms have the same meaning as those set forth in Sections 1300.71 and 1300.71.38 of Title 28 of the California Code of Regulations.

Dispute Resolution Process

Note: For FEP PPO, Blue Shield of California handles the dispute resolutions for professional Providers. Blue Shield of California is not an Anthem affiliate.

1. **Definition of a Provider or Facility Dispute.** A written notice to Anthem **challenging, appealing or requesting reconsideration of a Claim** (or a multiple group of substantially similar Claims that are individually numbered) or clinical determination that has been denied, adjusted, contested or seeking resolution of a contract dispute (or multiple group of substantially similar contractual disputes that are individually numbered); or disputing a request for reimbursement of an overpayment of a Claim. Each Provider or Facility dispute must contain, at a minimum, the following information: Provider or Facility's name, tax identification number, contact information and:
    - If the Provider or Facility dispute pertains to an alleged denial of a Claim, underpayment of a Claim, or a request for reimbursement of an overpayment recovery made by Anthem Blue Cross on a Claim, the following must be provided:
        - A clear identification of the disputed Claim
        - The date of service
        - A clear explanation of the basis for which the Provider or Facility believes the payment amount should be
        - Requested additional information from Anthem's Grievances and Appeals department
        - Request for reimbursement for the overpayment of a Claim, contest, denial, adjustment or other action;
    - If the Provider or Facility dispute is not about a Claim, a clear explanation of the issue and the Provider or Facility's position on the issue; and
    - If the Provider or Facility dispute involves an enrollee or group of enrollees:
        - Their name(s) and identification number(s)
        - A clear explanation of the disputed item, including the date of service and Provider or Facility's position on the dispute
        - Enrollee's written authorization for the Provider or Facility to represent the enrollees

2. **Sending a Provider or Facility Dispute to Anthem Blue Cross.** Each Provider or Facility dispute submitted to Anthem Blue Cross must include the information listed above. The **Provider and Facility Dispute Resolution Request** form is available in the **Exhibits** section of this Manual.

   Provider or Facility disputes must be sent to the following address:

   Anthem Blue Cross
   P.O. Box 60007
   Los Angeles, CA 90060-0007

   Or submitted through the **Availity Portal**.

   For FEP PPO, Blue Shield of California handles the dispute resolutions for professional Providers. Use the following address:

   Blue Shield of California
   PO Box 272510
   Chico, CA 95927

3. **Time Period for Submission of Provider or Facility Disputes:**
   - Provider and Facility disputes must be received by Anthem Blue Cross no later than three-hundred sixty-five (365) days from Anthem Blue Cross' action that led to the dispute; or
   - In the case of inaction, Provider and Facility disputes must be received by Anthem Blue Cross no later than 365 days after the Provider or Facility's time for contesting or denying a Claim (or most recent Claim if there are multiple Claims) has expired.
   - Provider and Facility disputes that do not include all required information, as set forth above, may be returned to the submitter for completion. An amended Provider or Facility dispute, which includes the missing information, shall be submitted to Anthem Blue Cross within thirty (30) working days of the returned receipt date.
4. **Definition of a Provider or Facility Dispute.**

   Anthem Blue Cross will acknowledge receipt of all Provider and Facility disputes within fifteen (15) working days of the date of receipt. If Provider Dispute is received through the Availity portal, an acknowledgment letter will be sent within two (2) business days of receipt.
5. **Contact Anthem Blue Cross Regarding Provider and Facility Disputes.** All inquiries regarding the status of a Provider or Facility dispute or information about filing a Provider or Facility dispute must be directed to Anthem Blue Cross by "Type of Plan" at the telephone numbers listed in the "Claims and Correspondence Mailing Address" subsection of the Directory of Services. Providers can also check status in the Availity Portal.
6. **Instructions for Filing Substantially Similar Multiple Provider or Facility Disputes.** Providers and Facilities can use the **Provider Dispute Resolution Request** form to address substantially similar multiple Provider or Facility Claims, billing or contractual disputes. However, Claims may only be batched upon behalf of one (1) Requesting Party.

   These disputes may be filed in batches as a single dispute, provided that they are submitted in the following ways:
   - Sort Provider and Facility disputes by similar issue
   - Provide cover sheet for each batch

- Number each cover sheet
- Provide a cover letter for the entire submission describing each Provider and Facility dispute, with references to the numbered cover sheets

7. **Time Period for Resolution and Written Determination of Provider and Facility Disputes.** Anthem Blue Cross will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the Provider and Facility dispute or the amended Provider and Facility dispute and 30 calendar days for Medical Necessity appeals where there was a Medical Necessity review prior to discharge of the patient.
8. **Past Due Payment.** If the Provider of Facility dispute or amended Provider or Facility dispute involves a Claim and is determined, in whole or in part, in favor of the Provider or Facility, Anthem Blue Cross will pay any outstanding monies calculated to be due, as well as all interest and penalties required by law or regulation, within five working days of the issuance of the written determination. For more information concerning Claims submission instructions and Claims settlement practices, refer to the **Claims Submission** section of this Manual.

Meet and Confer

In the case of a Professional Provider dispute, following the appeal by the Provider, if a Provider continues to disagree with Anthem's decision, the Provider may request a Meet and Confer, and then, if necessary, arbitration, pursuant to the Agreement and the guidelines below. Meet and Confer and arbitration are not available to non-participating providers. The requirement for a Meet and Confer only applies to Professional Provider disputes. The Meet and Confer process does not apply to Facility disputes.

All Provider disputes must be submitted to, and processed through an appeal prior to requesting a meet and confer conference. The following procedures are applicable to all meet and confer requests submitted to Anthem on or after the effective date of this Manual.

Submit Meet and Confers electronically to: **calegalmeetandconfer@anthem.com**

Only if the Meet & Confer submission is too large to email, then Meet and Confers may instead be submitted to:

Anthem Blue Cross
Legal Department
Attention: Meet and Confer
21215 Burbank Blvd
Woodland Hills, CA 91367

For FEP PPO, professional Providers can send their meet and confer requests to:

Blue Shield of California
PO Box 272510
Chico, CA 95927

Prior to filing an arbitration demand over one or more disputed issues, the parties shall meet and confer in an effort to informally resolve the dispute. Unless otherwise agreed to by both parties, the meet and confer will be handled based upon the exchange of written information related to the disputed issue(s).

The party requesting the Meet and Confer (Requesting Party) shall provide all documentation and materials upon which it bases its position in the meet and confer. Any Meet and Confer request made by the Provider shall, at a minimum, contain the following information related to each patient Claim that is the subject of the Meet and Confer request: (1) patient's name, (2) patient's Anthem Blue Cross ID number, (3) applicable date(s) of service, (4) a copy of the written determination that was made by Anthem Blue Cross on the dispute when it was submitted for the appeal, (5) the Provider's expected reimbursement amount, (6) the manner in which the expected reimbursement amount was calculated by the Provider, and (7) an explanation as to why the Provider disagrees with the patient Claim determination made by Anthem Blue Cross during the Provider appeal.

For the particular types of issues set forth immediately below, the following additional information shall be submitted in connection with a meet and confer request:

Coding Issues

If a Claim was denied in whole, or in part, due to missing or incorrect Revenue codes, CPT codes and/or HCPCS codes, written documentation containing the required correct codes, together with proof that the corrected Claim was submitted within the Claims submission filing deadline set forth in the Agreement with Anthem.

Medical Necessity

The patient's complete medical records for the date(s) of service in dispute.

In the case of a medical necessity dispute, if satisfactory resolution is still is not reached through the Meet and Confer process, the Provider agrees to arbitrate the dispute, as set forth in the Provider's Agreement. The Provider may only commence arbitration after the dispute has been submitted for an appeal and then the Meet and Confer process. The Provider appeal and the Meet and Confer process shall not toll the running of the applicable statute of limitations for filing an arbitration demand. Therefore, the Provider is strongly encouraged to engage in the appeal process and Meet and Confer process in a timely manner.

Independent Review Organization

Certain Facilities have an Agreement with Anthem Blue Cross that requires that all medical necessity disputes (length of stay, level of care, or whether a procedure is investigational/ experimental) are to be resolved through a binding determination to be made by an IRO. If the Agreement with Anthem Blue Cross contains this dispute resolution provision and the Claim involves one where Anthem Blue Cross performs the utilization management and Facility appeal/Facility dispute resolution function for the Claim in dispute, Facilities are still required to first submit the dispute through an appeal made in accordance with the Provider and Facility Dispute Resolution Process described above.

Further, if the Agreement with Anthem Blue Cross contains this dispute resolution provision, Facilities may not submit medical necessity disputes for those Claims to arbitration. Instead, for all medical necessity disputes for those Claims, the Facility shall adhere to the Process below for a binding, final resolution of the dispute to be made by an IRO. If the Claim in dispute is not one where **Anthem Blue Cross performs the Utilization Management and Facility appeal/Facility dispute resolution functions, then this IRO process does not apply.**

1. For **each** disputed medical necessity Claim where Anthem Blue Cross performs the Utilization Management and Facility appeal/Facility dispute resolution function for the Claim in dispute, the Facility shall complete and submit to Anthem Blue Cross a Facility Binding **Independent**

Review Organization (IRO) Request form. The form must be completed in its entirety. Copies of the form can be found in the **Exhibits** section of this Manual.

2. The completed form shall be mailed to: Anthem Blue Cross, Risk Unit AC-5L, P.O. Box 60007, Los Angeles, CA 90060-0007.
3. A **separate** form must be completed and submitted for **each** disputed medical necessity Claim;
4. The Facility may select one IRO to be used from a list of the two (2) IROs that Anthem Blue Cross will identify on the **IRO Request** form.
5. All submissions made pursuant to this section shall be made within the timeframe set forth in the Agreement with Anthem. If no timeframe is set forth in the Agreement with Anthem, then the submission of a medical necessity dispute to the IRO process shall be made no later than one-hundred eighty (180) days following an adverse determination made by Anthem Blue Cross in the Provider Dispute Resolution process.
6. Once an IRO Request is submitted, Anthem Blue Cross will submit the Request, along with all medical records previously submitted by the Facility to Anthem Blue Cross, to the IRO designated by the Facility. The Facility may not submit additional medical records in conjunction with the IRO Request. It is expected that all medical records necessary for Anthem Blue Cross to make a medical necessity determination would have been submitted by the Facility no later than its appeal to Anthem Blue Cross in the Provider Dispute Resolution Process.
7. When the designated IRO makes its determination, copies of the written determination will be transmitted to both Anthem Blue Cross and the Facility.
8. If the IRO rules either in whole, or in part, in favor of the Facility, Anthem Blue Cross will directly adjust and pay the Claim through its Claims system in accordance with the determination made by the IRO.
9. Unless the Agreement with Anthem Blue Cross provides otherwise, the cost of the IRO shall be equally divided between Anthem Blue Cross and the Facility.

Dispute Resolution, Mediation, and Arbitration

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Agreement (the “Agreement”) or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. To the extent possible, the language of the Agreement and the Provider Manual should be read together and harmonized if there are details in one not addressed in the other.

A. Fees and Costs

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

state rule counterpart awarding a party its fees if that party requested fees under Rule 11, or the respective state court counterpart rules in its initial pleadings. Notwithstanding this provision, the arbitrator or panel of arbitrators may issue an order in conjunction with a party's offer of judgment in accordance with Federal Rule of Civil Procedure Rule 68.

B. Location of the Arbitration

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

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

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

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

D. Consolidation

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

E. Discovery

The Parties recognize that litigation in state and federal courts can be costly and burdensome. One of the parties' goals in providing for disputes to be mediated and arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the D Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval and entry.

F. Decision of Arbitrator(s)

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

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

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

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

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

G. Interest

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

H. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process including, but not limited to, materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are

confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude Anthem or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers, retrocessionaires or affiliates and Other Payers whose Claims have been at issue in the arbitration, including Administrative Services Only (ASO) groups and other Blue Plans.

Member Grievances and Appeals Process

Introduction

The Anthem Blue Cross Member grievances and appeals process offers Members, their authorized representatives, health care Providers and Facilities acting on behalf of Members the right to request a formal appeal evaluation of any denial issued by Anthem Blue Cross. Anthem. Blue Cross must comply with current federal and state regulations and accreditation performance standards (e.g., NCQA) that apply to processing Member grievances and appeals. Anthem Blue Cross must ensure that internal review processes are fair and impartial.

The Anthem Blue Cross Grievances and Appeals (G&A) Department administers the formal grievances and appeals process. G&A is responsible for ensuring a consistent procedure for documenting, investigating, resolving, and responding to Member issues in a timely and accurate manner. The Anthem Blue Cross Behavioral Health (BH) G&A Department is responsible for addressing Member grievances and appeals related to behavioral health care services and treatment. The term “G&A” used throughout this section refers to both Medical G&A and BH G&A, unless otherwise specified.

Anthem Blue Cross and some Anthem Blue Cross Life and Health plans require Members to file an appeal or grievance no later than 180 days following the date they received a denial notice or the date of an incident or dispute. G&A will follow the timeframe limit that is specified in the G&A Member’s Evidence of Coverage (EOC) or Summary Plan Description (SPD). If the date of the last denial notice or the date of the incident or dispute cannot be determined, G&A will proceed with the appeal or grievance review as filed. If a party responds with a written explanation showing good cause for missing the required timeframe, G&A will consider the circumstances that kept the Member from making the request on time and whether organizational actions might have misled the Member. Exceptions are made for good cause.

Background Information

The California Department of Managed Health Care (DMHC) regulates managed health care HMO/POS/PPO plans and Medicare Supplement business. The California Department of Insurance (CDI) regulates Anthem Blue Cross Life and Health Insurance Company plans and Medicare Supplement business in California. Centers for Medicare & Medicaid Services (CMS) regulates Anthem Blue Cross Medicare Advantage and Medicare Supplement business in California. Under applicable law

and regulations, the DMHC requires that every managed care health plan establish and maintain a grievance system through which Members may submit grievances to the plan.

Availability of Member Grievance Process and Forms

Section 28 CCR 1300.68(b)(6) and (7) of the Knox Keene Act and Regulations requires Health Plans to require that Member grievance forms and a description of grievance procedures are readily available at each contracted Provider's office or Facility. Grievance forms must be provided by the Provider to the Member upon request.

The Member grievance form can be found in the Exhibits section of this Manual. It is important to implement processes to provide grievance forms and a description of Anthem's grievance procedures to Anthem Members promptly upon request.

The Provider or Facility Agreement with Anthem requires Providers and Facilities to comply with all applicable laws and regulations which includes an obligation to cooperate with Anthem's administration of its grievance program.

Additional information can be accessed on the process of submitting Member grievances and appeals, grievance forms, definitions and appeal rights, on Anthem's website at **anthem.com/ca/forms.** Go to **View by Topic** and click on the drop-down menu and select **Grievance & Appeals**, then select the desired resource link.

Member Representation

The appeal process provides for a Member, Member's authorized representative, and health care Provider or Facility rendering care, acting on behalf of a Member, to submit a verbal or written appeal to Anthem Blue Cross. Members may choose anyone they wish to represent them, at any level of the appeal process, including an attorney.

A signed designation of representative form (DOR) is not required when the Member's practitioner, acting on behalf of the Member, submits a pre-service or concurrent appeal. If a Member is a minor, or is incompetent or incapacitated, then the parent, guardian, conservator, relative or other designee of the Member, with supporting legal documentation, such as guardianship papers, health care power of attorney, or other appropriate documents, may submit the appeal.

For the purposes of this section, the term "Member" will refer to the Member, designated representative or health care Provider/ Facility acting on behalf of the Member. G&A follows HIPAA privacy standards to ensure Member, medical record and data confidentiality.

Right to Submit Additional Information During Appeals Process

Members have the right to submit written comments, documents and other information related to the appeal request. This information will be accepted and taken into account during the appeal review even when such information was available and considered during the initial review. G&A will conduct a review of the appeal that does not give deference to the initial denial. G&A will fully investigate the content of the appeal, including all aspects of clinical care involved, and document its findings.

Formal grievance/appeal policies and procedures are available to the Member, the health care Provider and the Facility rendering care, upon request.

Custodial Parent Rights

In accordance with California Health and Safety Code requirements, a non-covered custodial parent (evidenced by a court or administrative order) of a covered minor is entitled to receive copies of the same correspondence sent to the Subscriber, the non- custodial parent. However, the custodial parent will not be notified in any cases where there are clear clinical and/or legal reasons in which potential harm could come to the minor as a result of such notification (such as in cases of family violence or abuse).

Language Assistance and Cultural Diversity

The Anthem Blue Cross grievance/appeal process is designed to serve the linguistic and cultural needs of its Member population, as well as the needs of Members with disabilities. G&A shall ensure that all Members have access to, and can fully participate in, the grievance system by providing assistance for those who speak a language other than English, have limited English proficiency, or have a hearing impairment or other communicative impairment. Such assistance includes translation of grievance procedures, forms, and plan responses to grievances, as well as access to interpreters, telephone relay systems and other devices that aid disabled individuals to communicate. G&A associates are trained to ensure that Members, who submit oral or written grievances and appeals in a language other than English, are sent responses in the same language as the Member submitted.

Initial Determination Process and Denial Notification Procedures

The initial decision to approve or deny requests for prospective, concurrent or retrospective health care services is made by Anthem Blue Cross (for certain types of health care services) for Members enrolled in PPO plans. If Anthem Blue Cross denies a requested health care service or Claim, Members and their Providers are sent written notification of the denial and a description of appeal rights.

Process for Submitting Member Grievances and Appeals

Members may request a grievance or appeal regarding any denial of authorization resulting from a request for a prospective, concurrent or retrospective review of health care service. Member grievances and appeals may be submitted in writing or verbally. Members and their representatives also have the option of submitting grievances/appeals online to Anthem Blue Cross via the Internet. The grievance website is accessed at **anthem.com/ca/forms**. Go to **View by Topic** and click on the drop-down menu and select **Grievance & Appeals**, then select the desired resource link.

Grievance forms are posted in the Anthem's threshold languages on the website. The completed grievance form is then routed to the Customer Service Inquiry Tracking System for distribution to the appropriate G&A area. The Member may also print the form, complete it, and send it to Anthem Blue Cross at the address below.

Grievances or appeals received verbally by the Customer Service Unit are documented on the Customer Service Inquiry Tracking System and routed to the G&A unit for investigation and resolution. Grievances or appeals received verbally by the Utilization Management (UM) Department are documented in a clinical documentation system and routed to the appropriate G&A unit.

The Member or Member's representative should document the circumstances surrounding the grievance/appeal and submit this information along with any available medical documents, including medical records or Claims to Anthem Blue Cross. Members may refer to their EOC or contact Anthem Blue Cross Customer Service for further information on the G&A process.

Members may submit a grievance and/or appeal in writing to G&A at the following address:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310
Fax: 818-234-1089

For FEP PPO, use the following address for professional inquiries:

Blue Shield of California
P.O. Box 272510
Chico, CA 95927
Phone: 800-824-8839

Medicare Advantage Members may submit a grievance and/or appeal in writing to Medicare G&A at the following address:

Anthem Blue Cross
Medicare Complaints Grievances and Appeals Department
4361 Irwin Simpson Rd – OH 0102-C535
Mason, OH 45040

Acknowledgement and Investigation of Appeals

Grievances and appeals are acknowledged in writing within five calendar days of the health plan receipt date. The acknowledgement letter contains the following information:

- The date the grievance was received by the health plan
- A general explanation of the grievance process and timeframe
- The name, address and phone number of the health plan representative who may be contacted about the grievance
- A statement that the Member may submit additional written comments, documents or other information in support of the grievance
- Plans regulated by the California DMHC must include the DMHC's toll-free telephone number, California Relay Services' telephone number, and the DMHC's Internet address in 12-point boldface font Anthem Blue Cross will obtain the necessary medical information used in the initial denial, as well as additional medical information from the Provider, as appropriate. When a request for information is sent, the Provider is required to respond within seven to 10 calendar days of the request, or sooner depending on the clinical urgency of the case.

Members have a right to review their appeal file, present evidence during the appeals process and continue to receive coverage pending the outcome.

The appropriate administrative and/or clinical specialists will review the case, including any additional supporting information received. The individual(s) reviewing the appeal will not have participated in the original decision, and will not be a subordinate of the individual who made the original decision.

After Anthem Blue Cross has completed its review, a written statement of its resolution is sent to the Member and Provider within 30 calendar days of receiving the grievance/appeal. Appeal denial letters provide the rationale and criteria used in the decision and additional dispute resolution rights as stated in the Member's EOC, including the right to request an independent medical review (IMR), as applicable.

Members have a right to request a copy of the criteria used in the decision, as well as copies of relevant documents and records relied on in the appeal review. There is no charge to the Member for this information. Members may request this information by calling G&A at 800-365-0609 or the TDD line at 866-333-4823 for the speech and hearing impaired.

A written request for information should be mailed to:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310

For FEP PPO, use the following address/phone number:

Blue Shield of California
P.O. Box 272510
Chico, CA 95927
Phone: 800-824-8839

Expedited Appeals

Members or their representatives have the right to request an expedited appeal. Expedited appeals are cases involving an imminent and serious threat to the health of the Member including, but not limited to, severe pain, potential loss of life, limb or major bodily function. An expedited appeal review will automatically apply to inpatient admissions and continued stays, including health care services for Members who remain inpatient in a Facility after receiving emergency care.

When a grievance or appeal meets expedited criteria, Anthem Blue Cross must immediately notify the Member of his or her right to request assistance from the DMHC, as applicable to the Member's plan, and provide the Member with the DMHC's toll-free number and TDD line.

Members are not required to participate in Anthem Blue Cross' expedited grievance or appeal process, prior to contacting the DMHC for assistance.

When an appeal is expedited, all necessary medical information is gathered to make a determination. As needed, the Provider will be asked to submit medical records to Anthem Blue Cross within 24 hours of the request. Expedited appeals must be resolved within 72 hours of the Anthem Blue Cross receipt date. The Member is notified verbally and the Provider is notified verbally of the decision within 72 hours of the plan receipt date. Verbal notification is followed by written notification within three calendar days of receipt.

The written notice will include the decision, rationale, applicable review criteria used in the decision and, if denied, a description of further dispute resolution options, which may include the right to request an IMR.

If the appeal request does not meet the criteria for an expedited review, the Member and Provider/practitioner are notified verbally and in writing within 72 hours of the request. The letter provides the reason why the request did not meet the Plan's expedited criteria and explains the standard appeal process, including the 30- calendar day resolution timeframe. The medical record should be submitted for the appeal.

See the section of this Manual titled *Member Grievances and Appeals* for additional information on Member appeals involving medical necessity or experimental/investigational issues.

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 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.

Reimbursement Requirements and Policies

This section includes reimbursement requirements and policies on how Anthem will reimburse Providers and Facilities for certain services. Reimbursement Policies are also published on anthem.com/ca be sure to check this manual and the website. Anthem reserves the right to review and revise policies when necessary.

To locate the policies online go to **anthem.com/ca.** Select **For Providers**, choose **Policies, Guidelines & Manuals** under *Provider Resources* in the horizontal menu. Scroll down to **Reimbursement Polices** and select **Access policies.**

Blood, Blood Products, and Administration

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

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

Changes During Admission/Continuous Outpatient Encounter

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

Change	Effective Date
Member's Insurance Coverage	Admission/First day of continuous Outpatient Encounter
Facility's Contracted Rate (other than DRG)	Admission/First day of continuous Outpatient Encounter
DRG Base Rate	Admission

Change	Effective Date
DRG Grouper	Discharge
DRG Relative Weight	Discharge
CPT & HCPCS coding changes	Discharge/Last day of continuous Outpatient Encounter

Comprehensive Health Planning

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

Courtesy Room

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

Different Settings Charges

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

Disallowed Charges

Only Charges for Covered Services are eligible for reimbursement. The Disallowed Charges (charges not eligible for reimbursement) include, **but are not limited to**, the following, whether billed under the specified Revenue Code or any other Revenue Code. These Guidelines may be superseded by the specific agreement. Refer to the contractual fee schedule for payment determination.

Eligibility and Payment

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

Emergency Room Supplies and Services Charges

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

Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions

(including IV or PICC line insertion at bedside), call back charges, nursing increments, therapy increments, and bedside respiratory and pulmonary function services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

General Industry Standard Language

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

Instrument Trays

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

Interim Bill Claims

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

IV Sedation and Local Anesthesia

Charges for IV Sedation and local anesthesia administered by the provider performing the procedure, and/or nursing personnel, are not separately reimbursable and is included as part of the Operating Room (OR) time/procedure reimbursement. Charges for medications-drugs used for sedation and local anesthesia are separately reimbursable.

Lab Charges

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

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

Labor Care Charges

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

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.

Neuromonitoring (Technical component)

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

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

Non-Covered Services, Supplies, or Treatment

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

Nursing Procedures

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

Operating Room Time and Procedure Charges

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

- The use of the operating room
- The services of qualified professional and technical personnel
- Linen packs, instrument packs, packs, post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire.
- Any supplies, items, equipment, and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services. Refer to Routine Supplies section of the manual.

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

- Increased operating room unit cost charges for the use of the robotic technology
- Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900
- Supplies billed related to the use of robotic technology.
- Reference the Robotic Surgical Systems Technology Assisted Surgical Procedures Reimbursement Policy.

Other Agreements

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

Personal Care Items

Personal care items used for patient convenience are not reimbursable. Examples include but are not limited to: breast pumps, deodorant, dry bath, dry shampoo, eye lubricants, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste.

Pharmacy Charges

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

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

Pre-Operative Care or Holding Room Charges

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

Preparation (Set-Up) Charges

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

Provider and Facility Records

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Members receiving Health Services. All of Provider's and Facility's records on Members shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient's welfare and safety during their confinement. This will include, but is not limited to cardiac monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

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

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

Respiratory Services

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

Routine Supplies

Any supplies, items and services that are necessary or otherwise integral to the provision of a specific service and/or the delivery of services in a specific location are considered routine services and supplies and not separately reimbursable in the inpatient and outpatient environments. Reimbursement for routine services and supplies is included in the reimbursement for the room, procedure, or observation charges.

Semi-Private Room Rate

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

Special Procedure Room Charge

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

Stand-by Charges

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

Stat Charges

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

Submission of Claim/Encounter Data

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

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

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

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

Supplies and Equipment

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

Tech Support Charges

Pharmacy Administrative Fees (including mixing medications), any portable fees for a procedure or service, patient transportation fees when taking a patient to an area for a procedure or test are not separately reimbursable. Transporting a patient back to their room following surgery, a procedure, or test, are not separately reimbursable.

Telemetry

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

Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/preoperative testing:

- 254 – Drugs incident to other diagnostic services 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic 35X – CT scan
- 40X – Other imaging services 46X – Pulmonary function 48X – Cardiology
- 53X – Osteopathic services 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology or other services 73X – EKG/ECG
- 74X – EEG
- 92X – Other diagnostic services

Non-diagnostic services are also considered part of pre-admission/pre-surgical/preoperative testing if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Member's admission as an inpatient.

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

Time Calculation

Operating Room (OR) –Time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR nurse's notes.

Recovery Room – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit (PACU) record.

Post Recovery Room – Time charges should be calculated from the time the patient leaves the recovery room until discharge.

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

Undocumented or Unsupported Charges

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

Video or Digital Equipment used in Procedures

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but

not limited to Ultrasound and Fluoroscopy guidance. Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are also not separately reimbursable.

Additional Reimbursement Guidelines for Disallowed Charges

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

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

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

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Foley/Straight Catheters, Urometers/Leg Bags/Tubing • Specimen traps/containers/kits • Tourniquets • Syringes/Needles/Lancets/Butterflies • Isolation carts/supplies • Dressing Change Trays/Packs/Kits • Dressings/Gauze/Sponges • Kerlix/Tegaderm/OpSite/Telfa • Skin cleansers/preps • Cotton Balls • Band-Aids, Tape, Q-Tips • Diapers/Chucks/Pads/Briefs • Irrigation Solutions • ID/Allergy bracelets • Foley stat lock • Gloves/Gowns/Drapes/Covers/Blankets • Ice Packs/Heating Pads/Water Bottles • Kits/Packs (Gowns, Towels and Drapes) • Basins/basin sets • Positioning Aides/Wedges/Pillows • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.) • Preps/prep trays • Masks (including CPAP and Nasal Cannulas/Prongs) • Bonnets/Hats/Hoods • Smoke Evacuator Tubing • Restraints/Posey Belts • OR Equipment/Supplies (saws, skin staplers, staples & staple removers, sutures, scalpels, blades etc.) • IV supplies (tubing, extensions, angio-caths, stat-locks, blood tubing, start kits, pressure bags, adapters, caps, plugs, fluid warmers, sets, transducers, fluid warmers, etc.)
0220 – 0222, 0229, 0250	Tech Support Charges • Pharmacy Administrative Fee (including mixing meds) • Portable Fee (cannot charge portable fee unless equipment is brought in from another Facility) • Patient transport fees
0223	Utilization Review Service Charges
263	IV Infusion for therapy, prophylaxis (96365, 96366) IV Infusion additional for therapy: • IV Infusion concurrent for therapy (96368); • IV Injection (96374, 96379)
0229, 0760 – 0762, 0769, 0270, 410 – 413, 0419	Other Charges

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Observations hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator • Respiratory assessment/vent management charges
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy • Compounding fees • Medication prep • Nonspecific descriptions • Anesthesia Gases – Billed in conjunction with Anesthesia Charges • IV Solutions 250 cc or less • Miscellaneous Descriptions • Non-FDA Approved Medications (subject to UM determination- Medical Policies)
0256	Experimental Drugs (subject to UM determination- Medical Policies)
0270, 0300 – 0307, 0309, 0380 – 0387, 0390 – 0392	Venipuncture (CPT Code 36415, 36416 or G0001) • Specimen collection • Draw fees • Phlebotomy • Heel stick • Blood storage and processing blood administration • Thawing/Pooling/Splitting, etc.
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment (including rentals) • Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and/or the room and board • Oxygen (ICU/CCU/Progressive) O.R., ER and Recovery • Instrument Trays and/or Surgical Packs • Drills/Saws (All power equipment used in O.R.) • Drill Bits • Blades

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Daily Floor Supply Charges • X-ray Aprons/Shields • Blood Pressure Monitor • Beds/Mattress • Patient Lifts/Slings • Restraints • Transfer Belt • Bair Hugger Machine/Blankets • SCD Pumps • Heel/Elbow Protector • Burrs • Cardiac Monitor • EKG Electrodes • Vent Circuit • Suction Supplies for Vent Patient • Electrocautery Grounding Pad • Bovie Tips/Electrodes • Anesthesia Supplies When Billed with Anesthesia Charges • Case Carts • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump and supplies • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • DaVinci Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation by same physician or procedure nurse) • Nursing care • Monitoring • Pre- or Post-evaluation and education • IV sedation and local anesthesia by same physician or procedure nurse • Intubation/Extubation • CPR
410	Nursing/Respiratory Functions: • Oximetry (94760, 94761, 94762) • Vent Management

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Disallowed Charges**
	• Postural Drainage • Suctioning Procedure • Nursing/Respiratory care performed while patient is on vent
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) stand-by charges
0940 – 0945	Education/Training
0270, 0272, 0300 – 0309	Bedside/Point of Care/Near Patient Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.)

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

* Subject to the Member's Benefit Agreement.

Clinical Practice Guidelines

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

guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to **anthem.com/ca.** Select **For Providers** and 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 his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the clinical practice guidelines.

Preventive Health Guidelines

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

The current guidelines are available online. To access the guidelines, go to **anthem.com/ca** Select **For Providers** and then select Policies, Guidelines and Manuals from the horizontal menu under Provider 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.

Medical Policies and Clinical Utilization Management (UM) Guidelines

Medical Policy Formation

The Anthem Medical Policy Committee (MPC) is the authorizing body for Anthem medical policy and clinical utilization management (UM) guidelines, which serve as a basis for coverage decisions. The MPC uses the resources of the Office of Medical Policy & Technology Assessment (OMPTA) and the Medical Policy & Technology Assessment Committee (MPTAC) for the development of Anthem

medical policy and clinical UM guidelines (collectively, “Medical Policy”) which MPC then reviews for use in California. The principal component of the process is the review for development of Medical Necessity and/or Investigational position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments, may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

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

The MPTAC is a multiple disciplinary group including physicians from various medical and behavioral 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.

The medical policies and clinical UM guidelines approved at MPTAC meetings are then further reviewed by the Anthem Medical Policy Committee (MPC) of the Physicians Relations Committee (PRC).The MPTAC approved medical policy position statements that are approved by the MPC are implemented in California (see below regarding clinical UM guidelines). The MPTAC approved medical policy position statements that are not approved by the MPC are not implemented in California. MPC and MPTAC voting Members and subcommittee Members are required to disclose any potential conflicts of interest. In the event that a Member discloses a conflict of interest, the associated Member will not participate in the vote specific to the proposed relevant Medical Policy.

To reach decisions regarding the medical necessity or investigational status of new or existing services and/or procedures, MPTAC (and its applicable subcommittees) relies on the medical necessity or investigational criteria included in the following policies:

- ADMIN.00004 Medical Necessity Criteria
- ADMIN.00005 Investigational Criteria

In evaluating the medical necessity or investigational status of new or existing services and/or procedures, the committee(s) may include, but not limit their consideration to, the following additional information provided to committee members:

- Collated results of electronic literature searches;
- independent technology evaluation programs and materials published by professional associations, such as:
    - Technology assessment entities;
    - Appropriate government regulatory bodies; and
    - National physician specialty societies and associations.

Additionally, for topics deemed to represent a significant change, or as otherwise required by law or accreditation, the medical policy team seeks additional input from selected experienced clinicians.

This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States.

Medical Policies approved by MPTAC are also communicated throughout the company for inclusion in the benefit plan and for implementation of the supporting processes.

Medical Policy decisions affecting Members are reported by health plans to and reviewed for input by the appropriate physician quality committees, which have the responsibility for reviewing MPTAC activities.

All medical policies and clinical UM guidelines are publicly available on **anthem.com/ca**, which supports Anthem's efforts to offer greater transparency for Providers, Members and the public in general. To access these documents on the Anthem website, select "Providers" and select "Policies, Guidelines and Manuals", then **View Medical Policies & Clinical UM Guidelines**, then "**Continue**" after reading the disclaimer. You can then search by keyword or code, or select the "Full List page". The Full List page has drop down menus for document type, category, status, date range (specific intervals), sort alphabetically (A-Z or Z-A) and by date (New to Old and Old to New).

The committee(s) is also responsible for reviewing and authorizing the use of clinical utilization management guidelines used as the standard Enterprise-wide solution for making determinations of medical necessity which are developed by external entities (for example, MCG care guidelines). These guidelines are also reviewed by the company's MPC. Clinical UM guidelines that are approved by MPC may be implemented in California while clinical guidelines that are not approved by MPC will not be implemented in California.

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

Accessing Medical Policies and Clinical UM Guidelines

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

To locate Medical Policy online, go to **anthem.com/ca**. Select **For Providers,** select **Policies, Guidelines & Manual**. Select "**View Medical Policies & Clinical UM Guidelines**". Search for policies or select "Full List page" to view. Page link is included below:

Medical Policy and Clinical UM Guidelines

Clinical UM Guidelines adopted by Anthem Blue Cross (PPO)

To locate Medical Policy and Clinical UM Guidelines and Prior Authorization requirements for **BlueCard** Out-of-area members, go to **anthem.com/ca**. Select **For Providers** at the top of the screen and then **Prior Authorization** under Claims in the horizontal menu. Scroll down to **Helpful Links** and select "**Medical Policy and Prior Authorization for Blue Plans.**" Page link is included below:

Medical Policy and Prior Authorization for Blue Plans

Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy may be developed to address the medical necessity of new technology and new

applications of existing technology while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services.

All medical policies and clinical UM guidelines are publicly available online. This provides greater transparency for Providers, Members and the public in general.

Other Criteria

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

Utilization Management

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

Utilization Management Program

The Utilization Management (UM) Program goal is to have Members receive the appropriate quantity and quality of healthcare services, delivered at the appropriate time, and in a setting consistent with their medical care needs. Providers and Facilities agree to abide by the following "UM" Program requirements in accordance with the terms of the Agreement and the Member's Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities shall comply with all requests for medical information required to complete Anthem's UM review. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined in the Utilization Management within this section.

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

UM Definitions

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 Providers, Facility and the Member documenting the UM determination.
6. **Pre-certification, Pre-service, Prospective / Requirement:** 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

Pre-Service (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 on a health care service (or supply) that requires pre-certification prior to its delivery to the Member.

Urgent Care Review: means request for medical care or services where application of the time frame for making routine or non-life threatening care determinations:

a. Could seriously jeopardize the life or health of the Member or the Member's ability to regain maximum function, based on a prudent layperson's judgment, or
b. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
c. In the opinion of a practitioner who is a licensed or certified professional providing medical care or behavioral healthcare services with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

Program Overview

UM review may be required for Prospective Review, 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.
- The review may consider such factors as the Medical Necessity of services provided, and whether the service involves cosmetic or experimental/investigative procedures.
- Inpatient admissions require UM review. UM 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/ca**, and select **For Providers**. Under the **Claims** heading, select **Prior Authorization**. 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.

Prospective Review and Continued Stay Review

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

B. Emergency inpatient admissions, require Providers and Facilities shall notify Anthem UM within forty- eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Anthem UM shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non- compliance see Failure to Comply with Utilization Management Program section.

Retrospective Utilization Management

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

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

Members may not be balance billed for penalty amounts. See below for additional information on penalties. For information on applicable penalties for non-compliance, see *Failure to Comply with Utilization Management Program* section.

Medical Policies and Clinical UM Guidelines

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

On-site/Electronic Medical Record Review (EMR)

If applicable, the Facility agrees to provide UM with 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/ca.

Failure to Comply with Utilization Management Program Processes

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

- Pre-certification review is required for elective inpatient admissions and outpatient procedures that require Pre-certification as specified by Anthem that are not submitted for review and a decision rendered **BEFORE** the service occurs will be subject to a fifty percent (50%) payment penalty. Providers and Facilities can only dispute the 50% penalty in order to present evidence of extenuating circumstances.
- Payment for emergency inpatient admissions will be subject to a fifty percent 50% penalty if the notification is not provided within forty-eight (48) hours of admission in the event that a Provider or Facility elects to dispute these reimbursement penalties. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

Extenuating Circumstances Approval List

- Insurance information was not available from the Member at the time of admission or incorrect information was received from the Member, due to illness, mental status, or language differences at the time of services. Including primary payer issues (e.g., Medicare, AKA admissions or VIP member admitted under a false name, etc.).

- Anthem health system problems prevented authorization from being obtained or Anthem health provides erroneous information, (e.g., misinformation about authorization requirements or Member eligibility).
- Admission or services received are court ordered.
- The need for another covered service was revealed and performed at the time the original authorized service was performed, the newly revealed covered service would not receive a late call penalty
- The Member presented with 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 data. These may include, but are not limited to:

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

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

Inpatient Electronic Data Exchange

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

Submit Pre certification Requests digitally

Using **Availity.com** to submit prior authorizations offers a streamlined and efficient experience for Providers or Facilities requesting inpatient and outpatient medical services for members covered by Anthem plans. Providers and Facilities can also use the Availity Essentials Authorization application to check authorization status, regardless of how the authorization was submitted. To submit digital prior authorizations log onto Availity.com and select the Patient Registration tab to access Authorizations and Referrals then select Authorization Request.

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

Peer to Peer Review Process

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

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 we will help the Member meet identified health care needs. This is reached through contact and team work 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.

In addition, assistance may be provided in coordinating care with existing community-based programs and services. This may include giving information about external agencies and community-based programs and services.

Case Management (CM) is a voluntary Member Health Benefit Plan management program designed to address any condition or comorbidity that may affect the Member's ability to manage their overall health. Case Management supports the Member through individualized assessments, customized care plans, education, benefit management and community resources to meet the immediate and long term needs of the Member. The nurse case manager in Anthem's case management program works with the treating physician(s), the Member and/or the Member's Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to help coordinate benefits for appropriate alternative treatment settings. The program requires the consent and cooperation of the Member or Member's Authorized Representative, as well as collaboration with the treating physicians. The length of time within case management is dependent on the complexity of the Member and number of identified health care needs. Long term Complex Case Management is provided for Members needing more than 30 days clinical support.

A Provider may refer a Member to Anthem's Case Management team by any of the following:

- Calling the toll-free phone number 1-888-613-1130
- Emailing a referral to **case.management@anthem.com**
- Using the provider portal to make an electronic referral.

Carelon Medical Benefits Management Inc.

Carelon Medical Benefits Management provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon Medical Benefits Management promotes optimal care 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, medical and radiation oncology, radiology, rehabilitation, sleep medicine and surgical.

Visit Carelon Medical Benefits Management's program microsite **here** to find program information, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to Carelon Medical Benefits Management ***Provider****Portal*$_{SM}$

Submit 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 Carelon Medical Benefits Management ***Provider****Portal*SM directly at **providerportal.com.** Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Call the Carelon Medical Benefits Management toll-free number: **877-291-0360**, Monday through Friday, 7:00 a.m. to 5:00 p.m. PT.

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 a 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 **Opti**Net Registration:

- Access Carelon Medical Benefits Management ***Provider****Portal* directly at **providerportal.com** *or at* **availity.com.**
- Once logged in, from the **My Homepage** screen, choose **Access Your OptiNet**
- Registration**.**
- Select the **Registration Type**, and choose the **Access Your OptiNet Registration** button.
- Complete requested information.
- The registration does not need to be completed in one sitting. Data can be saved throughout the registration process. Once the registration has been submitted, a score card will be produced 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 Carelon Medical Benefits Management ***Provider****Portal* Web Support at **800-252-2021**. For specific OptiNet customer services requests, contact **877-202-6543**. For any other questions, contact Anthem Provider Experience.

Quality Improvement Program

Quality Improvement (QI) Program Overview

The Quality Improvement Program Description (QIPD) explains the quality infrastructure and activities 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 covered 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 improves both health and healthcare costs. Anthem takes a leadership role to improve the health of its communities and is helping to address key healthcare issues.

Guided by its "Whole Health" strategy, Anthem uses digital-first solutions to support provision of exceptional experiences, affordability, quality and broadened access to care for consumers and communities. Digital solutions are the driving force behind shaping Anthem's strategy. Digital access to care is one of is the enablers that allows Anthem to create value, respond to societal shifts and meet market and consumer needs. Anthem's 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 with updates throughout the year and reflects the ongoing progress made on quality activities. The QI Work Plan includes measurable objectives for the year to determine how well the health plan is performing, including the approach to improving medical and behavioral healthcare and service addressing quality of clinical care, safety of clinical care, quality of service and Members' experience.

The QI Program is evaluated to assess outcomes of medical and behavioral health programs and activities toward established goals and objectives.

Goals and Objectives

The goals and objectives of the QI program support Anthem's vision and values. They are responsive to the changing needs of Members, Providers, Facilities and the healthcare community; and focus Anthem 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, analyze and improve clinical and service quality outcomes through standardized and collaborative activities.
- Evaluate performance in order to take action and respond to the needs of internal/external customers, including compliance with policies, procedures, contractual, regulatory and accreditation requirements.
- Build a safer and more equitable health system through the creation of a safety culture that improves the delivery of healthcare, health outcomes and enterprise alignment with national patient safety efforts.
- Identify and promote educational opportunities for Members, medical and behavioral health Providers.
- Advance health equity locally and nationally to improve lives and communities.
- Address the cultural and linguistic needs of eligible Members to promote improved health and healthcare outcomes for diverse Members.
- Help maximize health status, improve health outcomes and reduce healthcare costs of Members through effective Case Management (CM), which include 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

- **The Behavioral Health Case Management program** focuses on connecting Members with the appropriate level of services and timely application of evidence-based interventions geared toward successful and cost-effective management of the behavioral health (BH) condition, including psychiatric and substance use disorder. The program works with individual members and their families to explain the options available for BH treatment; advocates for coordination of care, both medical and BH; educates on symptoms and condition management to prevent further inpatient hospitalization stays; identifies and addresses barriers to treatment compliance; and offers resources and support to improve health outcomes for a better quality of life. The case manager and member work closely together to create an individualized care plan and monitor treatment compliance throughout the program.

  The primary goal of the BH CM program is to provide members who have chronic BH conditions with comprehensive services that address the member's needs, connect the member to the most appropriate level of care (in the least restrictive environment), and enhance treatment compliance to prevent unnecessary hospitalizations and improve the member's well-being.

- **The Disease Management (DM) program** includes Condition Care designed to help maximize health status, improve health outcomes and reduce healthcare costs for Members diagnosed with Asthma (pediatric and adult), Diabetes (type 1 and type 2, pediatric and adult), Coronary Artery Disease, Heart Failure and Chronic Obstructive Pulmonary Disease. This DM program was created and developed based on nationally accepted evidence-based Clinical Practice Guidelines. These guidelines are reviewed at least every two (2) years and program interventions and protocols are updated accordingly.

- **Well-being Coach Total** is health coaching that combines artificial intelligence (AI), digital and live telephonic/chat coaching to support Members of all risk levels with the channel that best fits their unique needs and preferences. It is a flexible, unified and fully integrated approach designed to provide a seamless experience for Members of all risk levels. Human-led health educators work one-on-one with high-risk Members to establish goals, address barriers, increase motivation and create a plan for tobacco cessation or weight management. Members of all risk levels can click-to-call or chat with these well-being coaches who have expertise in behavior change techniques. The Anthem market leading mobile coaching app is available for Members who want the convenience of personalized 24/7 digital lifestyle management coaching for food and nutrition, activity, weight loss, tobacco cessation and stress and sleep. This dual coaching solution supports entire populations, from the high-risk population looking for a higher-touch human-led coaching solution, to those of all risk levels who are looking to leverage mobile technology to manage and maintain their health.

Patient Safety

Anthem's mission is improving lives and communities. Patient safety is an important component in this mission. Anthem strives and reinforces efforts to build a safer, equitable high quality healthcare system; decrease the occurrence of patient safety events, potentially preventable conditions (PPCs) and hospital acquired and healthcare acquired conditions (both referred to as HACs); and ensure compliance with Federal and State regulatory requirements and BCBSA contractual requirements. We advocate for a safety culture that improves the delivery of healthcare, health outcomes, and alignment with national patient safety efforts. In doing so, we are committed to working with physicians, hospitals, and other healthcare partners.

Patient safety activities are designed to promote safe practices by identifying opportunities for improvement and refining processes throughout the healthcare delivery system, including as it applies to health disparities. We advocate for safe clinical care and services; collaborate and engage with medical and behavioral health Providers, as well as Members, concerning patient safety; and identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum.

We select areas of focus and monitoring by analyzing patient safety for members inherent to the quality of medical and behavioral healthcare delivery and services as it applies to Population Health Management programs that targets keeping members healthy; managing members with both emerging risk and with chronic illnesses; enhancing health equity by addressing disparities; and patient safety or outcomes across healthcare settings.

Our goal is to support physicians and hospitals in using appropriate processes, technologies, and strategies to address never events and healthcare acquired conditions, and, ultimately, to enhance the quality of care delivered to patients. Anthem strives to eliminate inpatient PPCs and HACs as defined by the Centers for Medicare & Medicaid Services (CMS), remaining consistent with CMS payment policy and as stated in Elevance's Health reimbursement policy/contracts. Reimbursement policies may be superseded by mandates in provider, state, federal or Centers for Medicare & Medicaid Services (CMS) contracts and/or requirements.

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/ca**. Select the **For Provider** link at the top of the landing page. Select **Policies, Guidelines and Manuals** (under the Provider Resources column), 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 under the "Laws and Rights That Protect You" category.

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 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 network Providers.

Continuity of Care/Transition of Care Program

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

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

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

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

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

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

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

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is a performance-based reimbursement program for hospitals in the network. The mission of Q-HIP is to help improve the outcome in a hospital setting and promote healthcare value by financially rewarding hospitals in the network for practicing evidence-based medicine.es.

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

- American College of Cardiology
- Centers for Medicare and Medicaid Services (CMS)
- Institute for Health Care Improvement
- National Quality Forum
- The Joint Commission
- The Society of Thoracic Surgeons

The Q-HIP measures can be benchmarked, tracked and compared within and among hospitals in the network, regardless of the health plan. To align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the CMS Hospital Compare database. By reducing variation in care, Q-HIP helps to improve the quality of care provided by participating Facilities, and helps support that more Members receive evidence-based clinical care.

Q-HIP strives to improve healthcare quality and to raise the bar by moving the bell-shaped “quality curve” towards high performance.

The annual meetings may be held with Q-HIP participating hospitals in the network, which offer an opportunity to share feedback regarding new metrics and initiatives. In addition, a National Advisory Panel for Value Solutions (NAPVS) provides input during the scorecard development process. The NAPVS is comprised of patient safety for Members and Quality leaders from health systems and academic medical centers across the United States. The NAPVS offers valuable advice and guidance as new measures and scoring methodologies are evaluated for inclusion in the program.

Overview of HEDIS®

HEDIS *(Healthcare Effectiveness Data and Information Set)* is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem’s HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 96 measures across 6 domains:

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

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

For more information on HEDIS visit **anthem.com/ca.** Select **For Providers,** Select **Forms and Guides** (under the Provider Resources column). Scroll down and select Forms and Guides, then scroll down and select in the Category drop down.

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

Overview of CAHPS

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

Health Plans report survey results to National Committee for Quality Assurance (NCQA), which uses these survey results for the annual accreditation status determinations and to create National

benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually 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).

Language Assistance Program

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

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

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

Objectives

The objectives of the LAP are to:

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

Threshold Languages

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

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

- For Members with addresses in California who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – CA must include English and the following two (2) threshold languages: Spanish and Chinese (traditional)

- For Members with addresses in Alaska who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – AK must include English and the following two (2) threshold languages: Spanish and Tagalog
- For Members with addresses in Arizona, New Mexico or Utah who are enrolled in a Federal Employee Program, the Notice of LEP Assistance – AZ/NM/UT must include English and the following two (2) threshold languages: Spanish and Navajo

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

Anthem Language Assistance Program Services

The following services are offered to Members, free of charge:

Face-to-Face Interpreters, Including Sign Language

Members, physicians, and other healthcare professionals may call the Customer Service telephone number located on the patient's health plan identification card, or the 24/7 Nurse Line after hours, to schedule face-to-face interpretive services during business hours. Every effort should be made to schedule face-to-face interpreters at least seventy-two (72) business hours in advance of appointment, and twenty-four (24) business hours are required to cancel interpreter. To request an interpreter, please call the Customer Service number located on his or her Membership ID card. Alternatively, Providers may call Provider Care at 1-800-677-6669 and request to speak to an interpreter.

TTY and Relay Services for a Member with Hearing or Speech Loss

Members may call 711, the national relay number or the relay service of their choice and have the relay operator contact Anthem's Member Service telephone number, which is located on the Members identification card.

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

Telephonic Interpreter Services Provided at All Points of Contact

Professional interpreters are native or near native speakers who are proficient in healthcare terminology and have been evaluated on a standardized assessment tool. Professional interpreters receive training regarding Health Insurance Portability and Accountability Act (HIPAA) and ethical standards. Points of contact include administrative, healthcare, and related services. Anthem interpretation vendors are contracted to have professional interpreters available in all languages typically within two (2) minutes in accordance with Anthem's CA Language Assistance Program.

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

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

Vital written materials are provided in six threshold languages:

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

Non-Standard Written Materials are Translated into a Threshold Language Upon Request

Materials that are Member-specific (e.g., denial, delay or claims letters) are sent in English with the offer of translation when requested. Translated materials are sent to the Member no later than twenty-one (21) days from the request date. To ensure timely translation of materials, physicians and other healthcare professionals should encourage their patients to contact Anthem at the Language Assistance Program phone number provided in the section titled "Directory of Services/Provider Resource Information" under Language Assistance Program. Alternately, physicians and other healthcare professionals can call Anthem's Provider Service Department at the Customer Service number on the back of the Member ID Card.

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

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

Telephone Interactions

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

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

qualified interpreter, the Members decision to use the minor as the interpreter must be documented in the patient record.

- Speak slowly, not loudly.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.
- Use open-ended questions to assess for understanding.
- If the Member refused interpreter services and is not demonstrating a full understanding, offer interpreter services again.
- If in-person, monitor non-verbal cues, such as facial expressions, positioning and body language. These may indicate understanding or confusion.

Tips For Working With Telephonic Interpreters

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

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

Information Available on DMHC's Website

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

Click on this link: **Contact Us (ca.gov)**

Alternatively, the notices and translations can be obtained online for downloading and printing from the DMHC website: **Contact Us (ca.gov)**. Hard copies can be requested by submitting a written request to the street address provided.

For CA Department of Insurance: Getting Help (ca.gov)

Medical Record Standards

Anthem has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential Member care

and quality review. Anthem performs medical record reviews to assess whether network primary care physicians (PCPs) are compliant with current medical record standards.

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires Providers and Facilities to comply with Anthem's standards for medical record documentation.

Medical record audits/reviews are performed annually on a percentage of randomly chosen PCPs contracted for Anthem's managed care products for Medicare Advantage networks and commercial State(s) with medical record regulatory requirements. For purposes of medical record audits/reviews, a PCP is defined as family medicine, general medicine, internal medicine, pediatrics and obstetrics/gynecology (when acting as a PCP). A random sampling of these PCPs is identified in the current year and abstracted from the HEDIS® data collection process.

Medical Record Criteria

1. The medical record will be evaluated for the following criteria:
2. Every page in the record contains the patient name or ID number.
3. Allergies/No Known Drug Allergies (NKDA) and adverse reactions are prominently displayed in a consistent location.
4. All presenting symptom entries are legible, signed, and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.
5. The important diagnoses are summarized or highlighted.
6. A problem list is maintained and updated for significant illnesses and medical conditions.
7. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
8. History and physical exam identifies appropriate subjective and objective information pertinent to the patient's presenting symptoms, and treatment plan is consistent with findings.
9. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record. (The clinical reviewer should see evidence of documentation of appropriate follow-up recommendations and/or non-compliance to care plan).
10. Documentation of Advance Directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent part of the medical record for adult patients is encouraged.
11. Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or facilities if there is reference to referral or care provided elsewhere. The clinical reviewer will look for a summary of findings or discharge summary in the medical record. Examples include progress notes / reports from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.
12. Age appropriate routine preventive services/risk screenings are consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

Culturally & Linguistically Appropriate Services

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

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

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

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

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

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

The My Diverse 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, 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 the programs are developed in partnership with the Blue Cross and Blue Shield Association (BCBSA) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME providers as Blue Distinction Centers for Specialty Care. Using objective information and input from the medical community, the BCBSA has designated hospitals, ambulatory surgery centers (ASCs), physicians, and/or clinics as Blue Distinction Centers (BDC) that are proven to outperform their peers in the areas 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 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/ca**. 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, combined heart/lung, liver, kidney, and bone marrow/stem cell transplant, and adult liver, combined kidney, pancreas, kidney, combined kidney/pancreas.

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+ (BDC)+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 21 percent more cost-efficient than non-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.

Bariatric Surgery

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

Cancer Care

- Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, hospitals, and accountable care organization (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 Agreement with their local BCBS Plan that has value- based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.
- Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009.
- Studies confirm that as many as eight out of ten Americans suffer from some sort of back pain. Many ways to treat back pain are available for Providers to work with Members, to guide them toward the most appropriate recommendation for their situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than

non- designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.

- In 2019, Blue Distinction Specialty Care Program for Spine Surgery expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an onsite ICU.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, cervical and lumbar fusion, cervical laminectomy, lumbar laminectomy/discectomy and decompression procedures.
- To date, Anthem has designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

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

Maternity Care

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise, a commitment to quality care, and safety during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01), Cesarean Section (PC-02) and selected patient experience measures at the Facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). As well as additional measures to support safe practices in childbirth.

Substance Use Treatment and Recovery

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

Ventricular Assist Devices

- Anthem's Center of Medical Excellence Ventricular Assist Device (VAD) launched in 2017. VADs are implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure.
- According to the Centers for Disease Control and Prevention Heart failure reports that about **6.2 million** adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

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

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

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

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 medical records, itemized bills. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies.

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

Definitions

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

- Agreement means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Member(s).
- Audit Appeal means a written request with supporting documentation to Anthem from a Provider or Facility to reconsider a payment determination.
- Audit Appeal Response means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means post payment evaluation of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining appropriate reimbursement under the terms of the Agreement.
- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related function on behalf of Anthem.
- Provider or Facility means an entity with which Anthem has a written Agreement.

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

Documents Reviewed During an Audit or Review:

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

A. Confirm that Health Services were delivered by the Provider or Facility

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

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

   Auditors/Reviewers may review Supporting Documentation including the Member's health record documents. The health record includes the clinical data on diagnoses, treatments, and outcomes. A health record generally includes pertinent information related to care and must support services billed by the Provider or Facility.

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

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

Policy

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

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

1. A Provider's or Facility's physical or electronic address may be confirmed prior to sending an initial request for supporting documentation.
2. When a response is not received within thirty (30) days of the date of the initial request, a second request will be sent.
3. When a response is not received within fifteen (15) days of date of the second request, a final request will be sent.
4. 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 offsets/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 offsets/recoupments.

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

Procedure

- **Review of Documents.** Anthem or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.
- **Desk or Off-site Audits:** Anthem or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem's request for additional documentation.

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

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

  Provider or Facility Audit Appeals: See Audit Appeal Policy.
- **On-site Audits:** Anthem or its designee may, but is not required to, conduct Audits on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable workspace for Anthem's

or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization.

When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available.

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

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

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

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

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

- **Scheduling of Audit (Hospital Bill Audits Only).** After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
- **Rescheduling of an Audit.** Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem

or its designee due to Provider's or Facility's rescheduling. Should the Provider or Facility fail to work with Anthem, or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

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

Audit Appeal Policy

Purpose

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

Procedure

1. 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 within thirty (30) business days of the date of the Provider's or Facility's receipt of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Appeal should address 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 thirty (30) business days unless expressly prohibited by contractual obligations or applicable law.
2. Upon receipt of a timely Appeal, complete with any supporting documentation Provider or Facility would like to provide, Anthem or its designee shall issue a written acknowledgement to the Provider or Facility of the receipt of the appeal within fifteen (15) calendar days. Anthem will make an appeal determination and communicate it to the Provider or Facility within thirty (30) calendar days. Anthem's determination shall address each matter contained in the Provider's or Facility's Appeal. Determination shall be sent via email, mail or portal to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and supporting documentation. ,
3. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem shall begin recoupment of the amount contained in Anthem's Appeals response, and a confirming recoupment notification will be sent to the Provider or Facility.

4. Upon receipt of a timely Provider or Facility appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Anthem'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
5. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's final Appeal Response to send a remittance check to Anthem. If no remittance check is received within the fifteen (15) calendar day timeframe, then Anthem shall recoup the amount contained in Anthem'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 to ensure that. This ensures 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/ca, scroll to the bottom footer and click on "**Health Care Fraud Prevention**" to be directed to the **fighthealthcarefraud** education site; at the top of the page click "**Report it**" and complete the "**Report Waste, Fraud and Abuse**" form.

- 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/Facility** Fraud, Waste and Abuse (FWA):

- Altering medical records to misrepresent actual services provided
- Billing for services not provided
- Billing for medically unnecessary tests or procedures
- Billing professional services performed by untrained or unqualified personnel
- Misrepresentation of diagnosis or services
- 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: We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or may advise of further action.
- Medical record review: We review medical records to investigate allegations or validate the appropriateness of Claims submissions. Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review. Prepayment Review: Specific to a Provider or Facility under investigation, a certified professional coder in the SIU evaluates Claims prior to payment Edits in Anthem's Claims processing systems identify these Claims for review to prevent automatic claim payment in specific situations.
- Recoveries: We recover overpayments directly from the provider. Failure of the provider 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
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 contact Availity Essentials section of the manual or contact Availity Client Services at 800-AVAILITY (282-4548) for more information.

Our company 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 Pre-Payment Review

One method Anthem uses to detect FWA is through pre-payment 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 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 any appropriate explanation for unusual may have an opportunity to explain their coding, documentation, and/or billing practices. If the review results in a determination that the Provider's or Facility's 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 a 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 rejection of the Claim under review. During the pendency of the prepayment review, if requested, the Provider or Facility will be given the opportunity to request a discussion of their pre-payment review status.

Under the pre-payment 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 pre-payment 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 pre-payment 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.

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

Pharmacy and 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 thirty-first (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.

Heath Insurance Marketplaces (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.

In addition to requirements and expectations in this PPO/EPO Manual for Marketplace business, critical updates about the products offered on the California exchange through Covered California and the networks supporting these ACA compliant Plans, additional information about the products offered on California exchange through covered California can be found on anthem.com/ca, Providers, Provider Resources, Select Forms and Guides, , select Affordable Care Act Compliant Health Plan Quick Reference Guide.

Affordable Care Act (ACA)-compliant Health Plans Quick Reference Guide

Updates about Anthem's ACA compliant health plans and the networks supporting these plans are published in Anthem's provider newsletter and sent via Anthem's email service. To access the newsletter, go to **anthem.com/ca/provider/news**. The option to sign up for Provider Communications updates is also on this page.

Additional information and current communications about Health Insurance Exchanges can be found from the provider homepage at **anthem.com/ca**.

Collection Practices

PPO/EPO providers shall maintain fair and reasonable collection practices that comply with applicable laws, rules and regulations.

Prescription Drugs

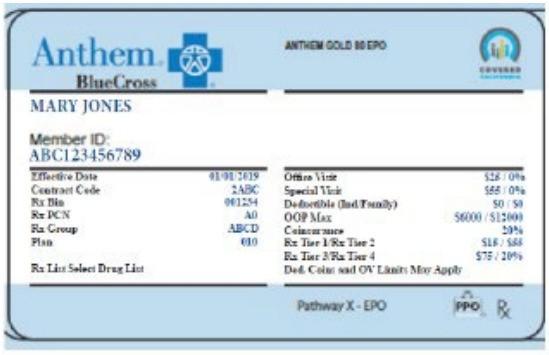
A current listing of Anthem's Exchange Formulary is available Anthem Formulary/Drug Lists. The Exchange Formulary is the Individual Select Drug List.

Provider Directory

Anthem submits a listing of participating providers in Exchange networks to Covered California on a monthly basis. PPO/EPO providers shall ensure Provider demographic and participation status updates are shared with Anthem in accordance with the Provider Responsibilities section in this PPO/EPO Manual, to ensure Anthem is providing up-to-date information to Covered California.

Important reminder:

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



Federal Employees Health Benefits Program

FEHBP Requirements

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

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

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

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

FEHBP Waiver requirements

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

FEHBP Member Reconsiderations and Appeals

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

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

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

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

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

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

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

FEHBP Formal Provider and Facility Appeals

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

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to 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 Web Site **fepblue.org** for additional information.

BlueCard Program Overview

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

Medicare Advantage

Refer to the Medicare Advantage website for additional information at:
anthem.com/ca/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

Workers' Compensation

Introduction

This manual, which is incorporated by reference to the Participating provider agreement, replaces any previous versions of the operations manuals for participating providers, facilities, and ancillary providers. This manual outlines all administrative policies and procedures you are obligated to comply with as required by your participating provider agreement. Your participating provider agreement also requires that you comply with all applicable federal and state laws, regulations, including but not limited to California Labor Code **4600**-**4616.7**, and California Code of (MPN) Regulations **Title 8 Chapter 4.5 Division of Workers' Compensation**. For more information please visit the Division of Workers' Compensation website **http://www.dir.ca.gov/dwc/MedicalProvider.htm**.

Medical Provider Network (MPN)

The Workers' Compensation Reform Legislation SB 899 was enacted to address many of the primary cost drivers and related issues regarding the State of California's Workers' Compensation system. This bill allows MPN Applicants (self-insured employers, insurance carriers, and Entities Providing Physician Network Services with the adoption of the SB 863 regulations effective 8/27/14) to submit a list of participating medical Providers to be included in their Medical Provider Network (MPN) for use by injured workers. The MPN Applicant has the exclusive right to determine the participating Providers in its MPN per Labor Code 4616d and California Code of Regulations 9767.3(c)(5)

Workers' Compensation PPO Network

Participating in the Workers' Compensation PPO Network makes you available for selection by MPNs accessing our network, however MPN Applicants have the exclusive right to determine the members of their MPN. To inquire about joining the Workers' Compensation PPO Network please email **WCContracting@anthem.com** or call Workers Compensation) Customer Relations at (866) 700-2168.

Why Participate in an MPN?

When an employer uses an MPN an injured worker must seek treatment from a provider selected to participate in the MPN and that has completed their physician acknowledgment. As an Anthem participating provider you are available for such selection and participation in MPNs. By participating in an MPN, injured workers will be channeled to you for treatment, which may subsequently include referrals to other participating Providers, Frontline/Occupational Health Clinics, hospitals, ambulatory surgery centers, laboratories, ancillary networks and Behavioral Health providers within the MPN.

Please contact the employer, insurer or claims administrator directly prior to providing non-emergency medical treatment or services, in order to obtain appropriate authorization. If you wish to confirm your MPN participation or do not wish to participate in a specific MPN please see the instructions for "Logging on to the Provider Affirmation Portal" where you can complete your physician acknowledgment or decline and opt out.

Please note the Provider Affirmation Portal is only for MPN clients who subscribe and access the Workers' Compensation PPO Network.

Maintaining Workers' Compensation PPO Network and MPN Status

To ensure you and/or your group are correctly listed in the dire97ctory and available to be selected for an MPN you must maintain an active participating provider agreement. If for any reason your participating provider agreement is terminated your termination letter serves a termination notice for all Anthem products and MPNs you were participating in.

In addition, you must keep your demographic information up to date as noted below. Please follow the steps below to ensure you continue to display in the online provider directories and to maintain MPN participation. If these steps are not followed, you could be removed from the network and/or Provider directory, which may affect your Workers' Compensation PPO Network and/or MPN status. If you are removed from the directory for non-compliance with our provider verification process, you will be notified of the removal in writing. Until you contact us to verify your provider demographics, or notify us of your desire to opt out of Workers' Compensation, your medical bills will continue to be reimbursed in accordance with your provider agreement.

It is important to ensure we maintain accurate directory data for you and your group, which requires you to provide timely updates to Anthem when information changes. Anthem requires up to date addresses for all providers at all locations, phone numbers and that you maintain a roster of participating physicians that treat Workers' Compensation as only Providers listed in the directory can be part of an MPN. Further, C.C.R. 9767.5.1 states any Medical Group that wishes to participate in the MPN shall maintain and update the active roster of physicians associated with the Medical Group and report any additions, terminations or demographic changes. Please contact Customer Relations at (866) 700-2168 to discuss options for submitting a roster. Groups that do not maintain accurate physician rosters may be excluded from the online directories pending updated rosters because we are required pursuant to C.C.R. 9767.3 to display individual physicians available for injured workers.

Per your participating provider agreement you must comply with the Anthem credentialing policy. If you leave a group that has delegated credentialing and are part of another participating group, if that group is not approved by Anthem to have delegated credentialing, you must initiate CAQH/Credentialing with Anthem within 60 days of leaving the delegated group to continue your participation. You must receive Anthem credentialing or re-credentialing approval to maintain network and MPN participation. To request credentialing you must start a new request through Availity at **Availity.com.** .

If you are not accepting any new workers' compensation patients (injured workers), and do not have any existing workers' compensation patients, please contact our Customer Relations department at (866) 700-2168 to complete the opt out process. Note: It is critical if you are currently treating your existing injured workers to be clear when receiving phone calls requesting an appointment that you **do** treat injured workers and your practice is full at this time to ensure continued display in the online provider directory and your participation status in any MPNs you may be participating in.

Demographic Updates

Notifying Anthem of specific demographic changes for example adding new locations, new providers etc. must be in writing, signed and dated by the practitioner.

Physician roster updates and demographic updates should be submitted directly to Availity at **Availity.com.**

If you have questions please contact Workers' Compensation Customer Relations at (866) 700-2168.

MPN Provider Acknowledgment Compliance

View MPNs you are selected for and maintain your MPN status by completing your Affirmations electronically online!

According to the California Department of Workers Compensation, as authorized by California Code of MPN Regulations (CCR) Title 8 Chapter 4.5 Subchapter 1 Article 3.5 Section 9767.5.1**,** an "MPN applicant shall obtain from each physician participating in the MPN a written acknowledgment in which the physician affirmatively elects to be a member of the MPN. An electronic acknowledgment using generally accepted means of authentication to confirm the identity of the person making the acknowledgment is allowed."

Workers' Compensation maintains a website Provider Affirmation Portal for clients who subscribe to the Provider Affirmation Portal where physicians and groups are able to view the MPN(s) that access the Workers' Compensation PPO Network and have selected the physician or group for MPN participation. A physician or group, or an agent or representative authorized on behalf of the providers can view all the MPNs they have been selected to participate in and complete the online form in the Provider Affirmation Portal to Affirm in or Opt Out of the each MPN. In addition, if the provider does not wish to visit the portal, you may call our Workers' Compensation Customer Relations team at (866) 700-2168 to assist in completing MPN Acknowledgement process in compliance with MPN regulations CCR §9767.5.1(e)(5)(B).

The Provider Affirmation Portal will also show your participation dates for MPNs that have been terminated. MPNs that terminate are updated in the Provider Affirmation Portal with the appropriate termination date as soon as Anthem is notified by the MPN. If you have questions about MPN terminations you will need to contact the MPN directly. Most MPNs maintain a website with MPN contact information. Please see the link to the DWC's list of MPN Website contact information for your convenience: **http://www.dir.ca.gov/dwc/MPN/ListApprovedMPN_Alpha.pdf**

Opting Out of Workers' Compensation PPO Network

If you do not treat existing or new workers' compensation injured workers' you may opt out electronically through the MPN Provider Affirmation Portal or by calling our Workers' Compensation Customer Relations at (866) 700-2168.

However, in the event you do treat a covered injured worker, you will be bound by the terms and conditions of your participating provider agreement and will be reimbursed accordingly.

Opting out of the Workers' Compensation PPO Network will terminate your participation in the Workers' Compensation PPO Network and will remove you from all MPNs that you are participating in. This may trigger Continuity of Care action by the claims administrator as described in section C.C.R. §9767.10. Further authorization by the MPN or Other Payors may not be provided and the injured workers you are treating at the time of your opt out may be transferred to other MPN providers for continued treatment.

If at some point in the future you elect to treat Injured Workers, you may request reinstatement to the Workers' Compensation PPO Network by contacting our Workers' Compensation Customer relations at (866) 700-2168. However, this will not automatically reinstate you into our clients' MPNs you were previously participating in. To confirm your MPN status after reinstatement in the Workers' Compensation PPO Network, please contact the insurance carrier, self-insured employer, or entity providing physician network services directly. For clients subscribing to the Provider Affirmation

Portal, you can electronically request reinstatement through the portal. To access the Affirmation Portal, you must log into Availity as instructed below:

Logging on to the Provider Affirmation Portal for Workers' Compensation

Access the Anthem provider portal known as *Availity.* If the medical provider is not yet signed up for this portal, instructions are provided below. To register for Availity:

- Go to **Availity.com** and click "Get Started."
- Complete the online registration wizard by clicking "Start Registration."
- You will receive an email from Availity with a temporary password and next steps. Applications are approved and temporary passwords sent within three to five business days.
- If you need further assistance, please contact Availity Client Services at: (800) 282-4548.
- Once you have logged into Availity, click on "Payer Spaces" at the top of the page. Select Anthem Blue Cross from the options available to you.
- Availity will take you to a welcome page for Anthem Blue Cross, click on "Resources" in the middle of the page.
- On the Resources tab locate the option for "MPN Provider Affirmation Portal."
- To make it a "Favorite", click on the heart icon next to it making the heart red. Favorites can be quickly accessed in the drop down menu in the upper right hand corner next to Payer Spaces.

MPN Regulations, Provider Selection, Referrals and Authorized Treatment

The DWC has established MPN regulations for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. MPNs have the exclusive right per California Labor Code 4616 (d) to determine the members of their Medical Provider Network. Participation in the Workers' Compensation PPO Network makes you available to be selected by an MPN. If you have been selected as an MPN Provider you must adhere to the guidelines below in order to assist the MPN in providing for the injured worker's medical needs and maintaining medical control for the life of the claim:

Refer within the MPN. Referrals must be made to Providers participating in the specific MPN for the employer, insurance carrier, or claims administrator.

Services obtained outside of the MPN may not be paid. If you have not been selected to participate in the specific MPN covering the injured worker, your services may be considered outside the MPN and will not be reimbursable unless specifically authorized by the employer or payor. You must contact the claims adjuster for authorization for any medical care outside of the MPN.

The injured worker may select a physician of his or her choice from within the MPN, at any point in time after the initial medical evaluation with an MPN physician. Selection by the injured worker of a treating physician and any subsequent physicians shall be based on the physician's medical specialty or recognized expertise in treating the particular injury or condition in question.

If a chiropractor is selected as a treating physician, the chiropractor may act as a treating physician only until the twenty-four (24)-visit cap is met unless otherwise authorized by the employer or insurer, after which the injured worker must select another treating physician in the MPN who is not a chiropractor. If the injured worker fails to do so, then the insurer or employer may assign another treating physician who is not a chiropractor pursuant to C.C.R. §9767.6.

If the injured worker disputes the diagnosis or treatment plan of the MPN Provider, there is a second- and third-opinion process established by the Administrative Director of the DWC included as part of the MPN policies and procedures.

Maintain medical records, records of accounts and payments, reports, and other documents that were necessary for the delivery of the medical services. These must be maintained for at least five years from the date of delivery of the medical service, and the obligation to maintain such records does not end on termination of the Agreement with the Prudent Buyer Network, Workers' Compensation PPO Network, ASH Network nor removal from related Medical Provider Networks. All such records, including records pertaining to the cost to the health care practitioner for delivery of the medical care and the payments received by the health care practitioner for such care, will be made available to the MPN, on request, during regular business hours.

Requests for Authorization (RFA) should be submitted to the Claims Administrator or Utilization Review Organization using the **DWC Form RFA**, following the treatment guidelines found in the Medical Treatment Utilization Schedule (MTUS). The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment. Services provided without proper authorization pursuant to CA Labor Code 4610 may not be reimbursable.

While a claim is under investigation the claims administrator will ensure payment for authorized medical services rendered, pursuant to CA Labor Code 5402 (c), until such time as a denial of the claim is made by the claims administrator.

CA Labor Code 3751 (b) prohibits any surcharges or other billings for Workers' Compensation health care services or balance billing the injured worker.

Demonstrate participation in educational activities for occupational medicine and Workers' Compensation, including, but not limited to:

- Regulatory requirements for Primary Treating Physicians and specialty physicians
- Workplace Health and Safety issues
- Vocational Rehabilitation
- Familiarity with the CA MTUS
- Knowledge of Evidence Based Medical Practice
- Understanding of the CA Workers' Compensation MTUS Formulary
- Impairment, Permanent Disability Ratings and Future Medical Awards

Physician Referrals within the Workers' Compensation PPO Network, "Other Payor" Medical Provider Network (MPN)

Please note that referrals to out-of-network, non-participating Providers or Providers not listed in the MPN in non-emergency cases and without prior written approval by claims administrator is prohibited under the terms of your Agreement and considered a material breach of the Agreement and may not be paid.

Provider agrees that in all circumstances where a referral to an out-of-network, non-participating Provider or a Provider not listed in the MPN is necessary, Provider will contact the claims administrator to request authorization of out of network or out of MPN treatment.

CA Labor Code 139.3 states it is unlawful for a physician to refer a person for medical services as defined in sections 139.3 and 139.31, whether for treatment or medical-legal purposes, if the

physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

For a list of MPNs accessing the Workers' Compensation PPO Network you may view the Anthem "Network Leasing Arrangement" available in the Availity portal.

To access the listing go online to Availity.com > Log into Availity > Payer Spaces > Anthem Blue Cross > Information Center > Administrative Support > Network Leasing Arrangements.

If you have questions about how to look up an MPN provider for any of the MPNs listed please contact our Customer Relations department at (866) 700-2168.

Medical Treatment Utilization Schedule (MTUS) and MTUS Formulary/Drug List

For all dates of injury, the "presumption of correctness" regarding appropriate medical treatment is the California Medical Treatment Utilization Schedule (MTUS). Information about these guidelines can be obtained by accessing **https://www.dir.ca.gov/t8/ch4_5sb1a5_5_2.html**

Any services, procedures, or surgeries performed must be in accordance with the MTUS and authorized by the claims administrator/payor. Arrangements by the DIR/DWC and The Reed Group, publisher of the "ACOEM Guidelines", allows for FREE access to the MTUS for Providers involved in the California Workers' Compensation System by signing up with the Reed Group at: **mdguidelines.com/mtus**.

Please note the California MTUS is subject to change, revision and update. It incorporates by reference the American College of Occupational (ACOEM) and Environmental Medicine's most recent treatment guidelines including:

- Ankle and Foot Disorders Guideline (ACOEM July 16, 2018)
- Cervical and Thoracic Spine Disorders Guideline (ACOEM October 17, 2018)
- Elbow Disorders Guideline (ACOEM August 23, 2018)
- Hand, Wrist, and Forearm Disorders Guideline (ACOEM January 7, 2019)
- Workplace Mental Health: Post-traumatic Stress Disorder and Acute Stress Disorder Guideline (ACOEM December 18, 2018)

For more information visit the DWC MTUS website: **http://www.dir.ca.gov/dwc/mtus/mtus.html**

MTUS Formulary and MTUS Drug List:

The CA WC Formulary went into effect 1/1/2018. It is new to the CA WC System, but exceedingly important for every provider to understand. It can be viewed on the DWC website, and the State and various organizations will have educational programs discussing important aspects of the medication list. It is the physician's responsibility to be familiar with the formulary and new terms such as "Exempt", "Non-Exempt", etc. Prescribing habits that don't align with the MTUS Drug Formulary may cause concern from a Quality Assurance perspective and affect participation in the Workers' Compensation PPO Network.

Guide for the Treating Physician

The DWC has established MPN regulations for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. A "Guide for the Treating Physician" in

the Workers' Compensation System has been written and is posted on our website in the California Resources and Forms section for Providers.

California Code of Regulations §9785 Reporting Duties of the Primary Treating Physician

Click the link, dir.ca.gov/t8/9785.html to view the regulation. Within five (5) calendar days of initial visit, a "Doctor's First Report of Injury or Illness (form 5021)" must be completed and sent to the Claims Administrator. This must be submitted by each new primary treating physician. The form must be completed including the information regarding frequency and duration of planned treatments, consultations, referrals, surgery or hospitalization, and the type, frequency and duration of planned physical medicine treatment on the reverse side of the form. These forms are available at **dir.ca.gov/dwc/forms.html**.

Additional reports (PR2) shall be submitted within twenty (20) days if the injured workers' condition undergoes a previously unexpected significant change, there is any significant change to the treatment plan reported previously, the injured worker is felt to be capable of returning to modified or regular work, the injured worker's condition requires him/her to leave work or requires changes in the work restrictions, the injured worker is released from medical care, or the injured worker is felt to be unable eventually to return to his/her usual occupation or the occupation in which the injured worker was engaged in at the time of the injury. When continuing medical treatment is provided, the PR2 shall be submitted no later than forty-five (45) days from the previous report but no later than twenty (20) days of the examination. These forms are available at **dir.ca.gov/dwc/forms.html**.

If a narrative report is submitted, it should be clearly titled "Primary Treating Physician's Progress Report" and should contain the same information as the PR2. A narrative report must have the mandated declaration below the signature of: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3."

When the physician determines that the injured worker's condition is permanent and stationary [maximum medical improvement (MMI)], the physician shall report this within twenty (20) days from the date of examination any findings concerning the extent of permanent impairment and limitations and any need for continuing and/or future care on the "Primacy Treating Physician's Permanent and Stationary Report," which is Form PR3 or PR4. These are available at **dir.ca.gov/dwc/forms.html**.

A Permanent Disability evaluation should be performed in accordance with the AMA Guides to the Evaluation on Permanent Impairment, which at the time of this document is the 5th Edition, subject to change. The physician is also able to refer the injured worker to another MPN physician for this report and if this is necessary, it should be discussed with the Claims Examiner.

Physicians are required to comply with all reporting requirements in order to maintain participation in the Anthem Workers' Compensation PPO Network. Refer to C.C.R. §9785.

Rules for Calculating Permanent Disability

The calculation of Permanent Disability is to be conducted in accordance with the *American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, presently utilizing the 5th Edition*. Information about this guide can be obtained by accessing **ama-assn.org**. Use of a more recent edition may be adopted in the future.

If you feel you are unable to write the permanent and stationary report, contact the claims examiner to refer the injured worker to another physician to prepare a report utilizing these guides. It is expected

that the great majority of providers will be able to supply this report without resorting to the need for another physician.

Other Responsibilities of the Primary Treating Physician in the Workers' Compensation MPNs

Availability

For non-emergency services, the MPN must have a primary treating physician available to see the injured worker for an initial visit within three (3) business days of the request.

For specialty services, the MPN must have a specialist available to see the injured worker within twenty (20) business days of the request.

Causation

When requested, the treating physician must address causation issues. Causation is the medical likelihood that the diagnosis is causally related to the mechanism of injury alleged to have occurred as related to employment.

Medication issues and AB1224 Compliance

Under the California Labor Code, the physician is to prescribe generic drugs unless clearly documented for reason that brand drugs are required and comply with the MTUS Formulary.

The physician is obligated to use the Pharmacy Benefit Program when made available to the injured worker and may not dispense medication from the office.

Physicians are required to register for and check the Controlled Substances Utilization Review and Evaluation System (CURES). Anthem physicians are required to utilize the CURES system in the management of injured worker medications to ensure safe and appropriate delivery of prescription medications.

The provision and prescription of compounded medications is not allowed as a part of the Workers' Compensation PPO Network unless in strict accordance with the CA WC Formulary.

The physician is to prescribe medication in accordance with MTUS Chronic Pain Treatment Guidelines. Prescribing of Opioids, Benzodiazepines, analogues, and other medications in dangerous quantities and dosages is considered a breach of the responsibility of the treating physician and can result in disciplinary action including termination for regulatory non-compliance.

The complete MTUS Formulary enacted by AB1124 can be found online
http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

Independent Medical Review (IMR), §9768

Anthem participating provider agreements require cooperation with Other Payor Utilization Review Organizations. Anthem physicians participating in workers' compensation are given an opportunity to appeal decisions made by the claims administrators Utilization Review Organization to deny or modify treatment recommendations with the Independent Medical Review (IMR) process.

For more information on the IMR process please visit the DWC website:
https://www.dir.ca.gov/t8/ch4_5sb1a3_6.html

Regulatory Compliance and Legislative Updates

AB1244 – Physicians, Practitioners or Providers Suspended by DWC

Effective 1/1/2017 this legislation supports LC 139.21 which requires the Division of Workers' Compensation (DWC) Administrative Director to suspend providers who abuse, defraud or pose a danger to participants in the workers compensation system. Details are below, along with links to the DWC website.

Anthem actively monitors the DWC list of "Physicians, Practitioners, or Providers Suspended" daily. If you are suspended by the DWC pursuant to LC139.21, you will immediately be removed from the online PPO provider directory; **https://www.viiad.com/anthemcompass/BCCWC/app/home.asp**.

In addition, your workers compensation participating provider agreement will be terminated and you will receive a notice of termination from the Workers' Compensation PPO.

From the Division of Workers' Compensation:

DWC Suspension List: **http://www.dir.ca.gov/fraud_prevention/Suspension-List.htm**

Providers on the list were issued suspension notices or suspension orders per Labor Code section 139.21(a). The suspension takes effect 30 calendar days after the notice is issued, unless it is appealed.

A suspension means that providers are unable to provide or obtain payment for any treatment, evaluation, or other service related to a workers' compensation claim.

*Labor Code **§139.21(a)** suspends providers from the system if they:*

A. Are convicted of a crime that involves:*

- fraud or abuse of the Medi-Cal or Medicare program, workers' compensation system, or any patient;
- the individual's medical practice as it pertains to patient care
- a financial crime relating to Medi-Cal, Medicare, or the workers' compensation system;
- the qualifications, functions, or duties of a provider of services.*

B. Suspension due to fraud or abuse from the federal Medicare or Medicaid programs.

C. Surrender or revocation of the individual's license, certificate, or approval to provide health care.

Providers suspended under (A) are also subject to consolidation and dismissal of all pending lien claims. **Lien consolidation hearings are posted online.*

AB1124 – MTUS Formulary

Effective 1/1/2018 the DWC has adopted an MTUS "Formulary" which places controls on what medications, quantities and durations can be utilized for injured workers.

Medications that are "non-exempt" require prospective Utilization Review prior to prescribing or dispensing. "Exempt" drugs do not require authorization if in accordance with MTUS. Some medications are deemed "Special Fill" and do not require prospective review prior to prescribing under certain conditions. Other medications may be classified as "Perioperative Fill" when surgery is required, and may not require prior authorization under certain conditions.

For more information please visit the DWC MTUS Formulary website:

http://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Formulary/MTUS-Formulary.htm

For more information on managing Opioids in the CA workers compensation system please see the DWC publication here: **https://www.dir.ca.gov/dwc/DWCPropRegs/MTUS-Opioids-ChronicPain/Final-Regulations/CleanCopy/Opioids-Guidelines.pdf**

SB1160 – Utilization Review in first thirty (30) days (LC4610) and Provider Liens (LC4615)

Utilization Review in the first thirty (30) days following injury, **LC4610**

Effective 1/1/2018, LC4610(b) states some medical treatment services that are provided in accordance with the MTUS within the first thirty (30) days following injury are not subject to prospective Utilization Review. However, if the MTUS requires Utilization Review for non-emergency services the physician must submit a Request for Authorization **(RFA)** to the Utilization Review Organization.

Medical Billing Timeframes:

Non-Emergency services provided pursuant to LC4610(b) in the first thirty (30) days shall be submitted to the employer, or its insurer or claims administrator, within thirty (30) days of the date the service was provided.

Emergency treatment services provided pursuant to LC4610(b) shall be submitted to the employer, or its insurer or claims administrator, within one-hundred eighty (180) days of the date the service was provided.

LC4610(c) defines some of the medical treatment services that require prospective utilization review, subject to change.

1. Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.
2. Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.
3. Psychological treatment services.
4. Home health care services.
5. Imaging and radiology services, excluding X-rays.
6. All durable medical equipment, whose combined total value exceeds two hundred fifty dollars ($250), as determined by the official medical fee schedule.
7. Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
8. Any other service designated and defined through rules adopted by the administrative director.

Criminally Charged Physicians and Providers: Automatic Stay on Liens, Payors May Defer Payment or Objection of Bills During Criminal Prosecution

Labor Code section 4615 places an automatic stay on liens filed by or on behalf of physicians and providers who are criminally charged with certain types of fraud. The automatic stay prevents those

liens from being litigated or paid while the prosecution is pending. DIR publishes a list of physicians and providers whose liens are stayed pursuant to this statute.

List of Criminally Charged Physicians and Providers Whose Liens are Stayed pursuant to Labor Code § 4615: **http://www.dir.ca.gov/Fraud_Prevention/List-of-Criminally-Charged-Providers.pdf**

Deferring Objection or Payment of Medical Bills, LC4903.2 and LC4615

Payors, including Other Payors, for Workers' Compensation have the right to defer objecting to or paying any bill or lien by or on behalf of a criminally charged provider as allowed by California Labor Code (the "Labor Code") Sections 4603.2(b)(5)(a) and 4615. Anthem and Provider acknowledge the rights of Other Payors to defer payment in accordance with such provisions of the Labor Code. For the avoidance of doubt, if an Other Payor exercises its right to defer the bills of the Provider who is criminally charged as allowed by such provisions of the Labor Code, the criminally charged Provider may file liens related to such bills pursuant to Labor Code Section 4903.5. This shall apply to (1) the criminally charged Provider regardless of whether such Provider is included in or not included in the Other Payor's MPN, or (2) any such criminally charged Provider the Other Payor has elected to remove from the Other Payor's MPN in accordance with Other Payor's MPN exclusive right under applicable law and regulations. Within thirty (30) calendar days of the filing of such criminal charges against Provider, Provider shall notify Anthem in writing of any criminal charges set forth in the above-referenced provisions of the Labor Code which are filed against Provider. Upon conviction or other disposition of such criminal charges against Provider, including but not limited to, the acceptance of a plea arrangement/agreement or other formal resolution of such charges, Provider shall notify Anthem in writing within thirty (30) calendar days of the conviction or other disposition of such criminal charges against Provider.

Network Leasing Arrangements

Anthem provides a listing of our Other Payors (Workers' Compensation Insurance Carriers, Self Insured's including Self-Insurer's Security Fund, a group of self-insured employers pursuant to CA Labor Code section 3700(b) and as defined by Title 8, C.C.R. §5402, a joint powers authority (JPA), the State and Third Party Administrators) who are leasing the network access to our Workers' Compensation PPO Network, which is comprised of our Prudent Buyer Network and may be used both as PPO and MPN.

This is updated on a monthly basis to include:

- New and Terminated "Other Payors"
- New and Terminated Medical Provider Networks (MPN)
- Which MPNs subscribe to the Provider Affirmation Portal

Please review monthly as terminations and additions can occur at any time. In order to have the most up-to-date information you must check the portal as will serve as your notification regarding the addition or termination of "other payors" leasing network access pursuant to California Labor Code (LC) 4616 and LC 4609.

To access a list of participating payors, go online to Availity > Log into Availity > Payer Spaces > Anthem Blue Cross > Information Center > Administrative Support > Network Leasing Arrangements.

If you have any questions regarding the status of any "Other Payor" or MPN please contact Customer Relations at (866) 700-2168.

Workers' Compensation PPO Network Online Provider Directory

The Workers' Compensation PPO Network provider directory is available by visiting our **Provider Finder website** and selecting "California." Assistance is also available by calling (866) 700-2168. This online Provider directory will identify Providers who treat work-related illness or injuries. To refer to other providers within an MPN, please visit the client MPN directory.

Network Pricing Questions and Independent Bill Review (IBR)

For questions regarding payment per your Participating Provider Agreement, please contact us at (866) 700-2168.

Note: If you have a question regarding how the California Official Medical Fee Schedule was applied, please contact the customer service number on the EOR. "Other Payors" adjudicate medical bills and provide Anthem with recommended reimbursement values they determined to be in accordance with the CA WC Official Medical Fee Schedule (OMFS) so that Anthem may apply the contracted rate accordingly. If you believe your payment was not calculated properly, you must submit a timely request to the claims administrator for a second review of the bill. If the Other Payor determines there was an error in their initial adjudication of the bill they can perform a re-evaluation/reconsideration of the OMFS allowance and send the bill back to Anthem for reconsideration of PPO pricing. If you disagree with the outcome of the second review, you may request an Independent Bill Review (IBR) within 30 days after service of the second review decision per LC 9792.5.7.

For more information on the IBR process please visit the DWC website **https://www.dir.ca.gov/dwc/ibr.htm.**

Participating Provider Dispute Resolution

Workers' Compensation has a Customer Relations team to assist in resolving disputes regarding reimbursement, where the OMFS is not disputed for compensable claims where services are authorized by the claims administrator. For matters that may be resolved pursuant to the Anthem Participating Agreement, including the validity, applicability, and reimbursement amount per the PPO Agreement, you may contact Anthem for assistance and to initiate the dispute resolution process, if necessary. If the payment dispute is regarding denial of services, unpaid Dates of Service, disagreements over OMFS calculations, or compensability decisions, please contact the Other Payor for assistance.

Further, under SB 863, the DWC affords medical providers who disagree with the amount paid by a claims administrator on a properly documented bill, a Second Bill Review (SBR) followed by Independent Bill Review (IBR) if still not satisfied. IBR applies to any medical service bill where the date of service is on or after January 1, 2013 and where the fee is determined by a fee schedule established by the DWC. The Anthem Participating Agreement does not preclude the provider from pursuing Second Bill Review (SBR) or Independent Bill Review (IBR) consistent with California Code of Regulations, Title 8, section 9792.5.6 and 9792.5.7 for OMFS-based issues.

As an Anthem contracted provider you have agreed to follow the dispute resolution process defined in your Anthem Participating Agreement.

Please note that the Workers' Compensation Appeals Board (WCAB) may determine that they do not have jurisdiction under LC 5304 as defined below.

Labor Code 5304:

The appeals board has jurisdiction over any controversy relating to or arising out of Sections 4600 to 4605 inclusive, unless an express agreement fixing the amounts to be paid for medical, surgical or hospital treatment as such treatment is described in those sections has been made between the persons or institutions rendering such treatment and the employer or insurer.

Should a lien matter be referred to Anthem for resolution, we will assess the pricing dispute to determine if the Participating Agreement may resolve the dispute. You may contact the Workers' Compensation Customer Relations team at (866) 700-2168.

Participating Provider Agreement Termination Notification

If your participating provider agreement is terminated for any reason you will only receive a notice of termination from Anthem as it relates to your PPO participation. When your participating provider agreement is terminated you will not receive individual notices of termination from each Medical Provider Network (MPN) for which you may participate. This may trigger Continuity of Care action by the claims administrator as described in section C.C.R. §9767.10. Further authorization by the MPN or Other Payors may not be provided and the injured workers you are treating at the time of your opt out may be transferred to other MPN providers for continued treatment.

Workers' Compensation Telehealth Services

As defined by the California Business and Professions Code 2290.5, "Telehealth means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care…"

Telehealth is used in the delivery of healthcare services through the use of a secure interactive audio video platform for the purpose of diagnosis, consultation, and/or treatment of a covered injured worker in a location separate from the servicing provider. Telehealth services do not include the use of audio-only telephone, facsimile machine, or electronic mail.

Nothing in this section shall preclude an injured worker from receiving in-person health care delivery services during a specified course of health care and treatment after agreeing to receive services via Telehealth if the physician is also a contracted with Anthem for a physical location in a Brick and Mortar setting.

Telehealth Privacy and Security

All laws regarding the privacy, security and confidentiality of health care information and a patient's rights to his or her medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

Telehealth services are used to support health care when the provider and patient are physically separated. Typically, the patient communicates with the provider via interactive means i.e. live audio/video feed. Participating provider shall be solely responsible for ensuring the security and privacy of their interactive audio/video platform. Such platform must at a minimum include technical, administrative and physical safeguards to ensure that all information pertaining to covered injured worker is protected in accordance with applicable law utilizing controls equivalent to those necessary for compliance with the Health Insurance Portability and Accountability Act (HIPAA).

Authorization to Deliver Telehealth in Workers Compensation

Anthem and its "Other Payors" monitor billing and practice habits to identify providers rendering treatment via Telehealth. Bills for unauthorized Telehealth services may be denied by the payor.

Consent: Regulatory Requirement

All laws regarding the privacy, security and confidentiality of health care information and a patient's rights to his or her medical information and personal information shall apply to Telehealth interactions. This section shall not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law.

Prior to the delivery of health care via telehealth, the health care provider initiating the use of Telehealth shall:

- Inform the patient about the treatment methods and limitations of treating a person through telehealth.
- Inform the patient about the use of Telehealth and obtain verbal or written consent from the patient for the use of Telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.
- Obtain the patient's written consent to disclose the patient's medical records, concerning the Telehealth interaction, to the patient's primary treating physician as may be required by applicable law.

Glossary

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

Accreditation. An evaluative process in which a health care organization undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.

Acupuncturist. A doctor of acupuncture (L.Ac.) who is qualified and licensed by the state.

Acute Rehabilitation. Rehabilitation is defined as restoration of a disabled person to self-sufficiency or maximal possible functional independence. An inpatient rehabilitation program utilizes an inter-disciplinary coordinated team approach that involves a minimum of three (3) hours rehabilitation services daily. These services may include physical therapy, occupational therapy, speech therapy, cognitive therapy, respiratory therapy, psychology services, prosthetic/orthotic services or a combination thereof**.**

Administrative Services Only (ASO) Contract. A contract under which a third-party administrator or an insurer agrees to provide administrative services to an employer in exchange for a fixed fee per employee.

Affiliate(s). A corporation or other organization owned or controlled, either directly or through parent or subsidiary corporations by Anthem.

Age/Sex Factors. The factors used to adjust the PMG's PMPM non-capitated expenses to account for cost variations attributable to the mix of Member age and gender. There are separate age/sex factors for professional capitation and institutional capitation.

Anthem Blue Cross. A health care service plan regulated by the California Department of Managed Health Care (DMHC).

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). An insurance company regulated by the California Department of Insurance (CDI), and an affiliate of Anthem Blue Cross.

Anthem Blue Cross HMO Participating Provider. A physician, medical group or IPA that has entered into a *Medical Services Agreement (Anthem Blue Cross HMO participating physician Agreement)* with Anthem Blue Cross to provide medical services to Anthem Blue Cross (HMO) plan Members.

Anthem Blue Cross HMO. A direct care prepayment plan(s) offered by Anthem.

Anthem Blue Cross HMO Care Management Analyst. An Anthem employee (RN) charged with resolving Member grievances and appeals, clinical benefit interpretation, and Member disenrollment issues.

Anthem Blue Cross HMO Case Manager. An Anthem employee charged with assisting PMGs with case management.

Anthem Blue Cross HMO Hospital. A hospital that has an agreement with Anthem to provide hospital services to HMO Members.

Anthem Blue Cross HMO Quality Management Representative. An employee of Anthem who is responsible for the Anthem HMO Quality Management programs.

Anthem Blue Cross Managed Care Network. The network of physicians, hospitals, facilities, and other health care professionals that have contracts with Anthem and one or more of its affiliates. Under these contracts, the physicians, hospitals, facilities, and other health care professionals agree to participate in Blue Cross HMO, Blue Cross POS and other programs conducted according to the Benefit Agreement.

Anthem Blue Cross Medical Policy. The Medical Policy & Technology Assessment Committee (MPTAC) is the authorizing body for enterprise medical policy and enterprise clinical Utilization Management (UM) guidelines (hereafter referred to as medical policy), which serve as a basis for coverage decisions. The Office of Medical Policy & Technology Assessment (OMPTA) supports the development of medical policy and clinical UM guidelines for the company. The principal component of the process is the review for development of medical necessity and investigational position statements for certain new medical technologies and/or procedures or for new uses of existing technologies and/or procedures. The technologies include devices, biologics and specialty pharmaceuticals, and behavioral health services.

Anthem Blue Cross Specialty Drug Pre-service Medical Review Program. Offers participating medical groups the option to obtain pre-service medical review for certain non-capitated specialty pharmaceutical drugs, which will be used on an outpatient basis through the Member's medical benefits.

Appeal. Is a formal request for reconsideration or reversal of an adverse determination (denial) made by Anthem Blue Cross.

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

Approved Screening Criteria. The written and/or online clinical guidelines and medical policies used to screen health care services for medical appropriateness. Inpatient guidelines include severity of illness, intensity of service and length of stay. Criteria are reviewed and approved at least annually by Anthem Blue Cross oversight committees. Oversight committees are primarily made up of practicing physicians. Criteria and guidelines are national in scope; developed with actively practicing physicians, Hospitals, Facilities or other health care professionals; and are reviewed and updated at least annually.

ASC X12. An Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI), founded in 1979. Its objective is to develop consensus standards to facilitate Electronic Data Interchange (EDI). A subcommittee of ASC X12 develops EDI standards for insurance.

ASC X12N Standard Format. The standards for electronic data interchange within the health care industry developed by the Accredited Standards Committee (ASC) X12N Insurance Subcommittee of the American National Standards Institute (ANSI).

Assignment. Agreement by the practitioner to accept any reimbursement from a third-party payor as payment in full for the services rendered. When a practitioner accepts assignment, balance billing for charges that were not paid in full is not permitted (except for collection of any deductible, copayment and/or coinsurance that the patient is required to pay).

Authorization. A general term used for clarity in this Facility Manual that refers to the review, approval and/or approval process inherent in the Anthem Medical Management Program. This

includes pre-service, concurrent and post-service reviews. Authorization should be requested prior to services being rendered. Common synonyms include “certification,” “prospective” and “review.”

Away-From-Home Care. Urgent care, away-from-home emergency care, routine care and follow-up care as defined in the HMO-USA Member plan certificate or Benefit Agreement.

Behavioral Health or Mental Health Facility. Any general acute hospital, psychiatric hospital, psychiatric health facility, chemical dependence recovery hospital, residential treatment center, day treatment facility, or other Anthem care Facility or outpatient setting approved by Anthem.

Behavioral Health Care. The provision of mental health and substance abuse services.

Behavioral Health Provider. Behavioral health care practitioners, including psychiatrists, psychiatric mental health nurse practitioners, psychiatric mental health nurses, psychologists, licensed clinical social workers, marriage and family therapists, and professional clinical counselors. For the provision of Applied BA, we’ve expanded the panel to include Board Certified Behavior Analysts (BCBAs). The Facility network includes hospital inpatient units, residential treatment centers, partial hospitalization programs, and intensive outpatient services and programs.

Behavioral Health Services. Those outpatient services, including therapy or acute care inpatient, residential, rehabilitation, and hospital day treatment outpatient services for the evaluation and treatment of mental disorders and substance abuse conditions, which are covered by a Benefit Agreement providing coverage for mental or nervous disorders, psychiatric disorders, substance abuse, or ABA. Hospital/facility services do not include long-term, non- acute care.

Benefit Agreement. The written agreement entered into between Anthem and a group or individual, pursuant to which Anthem indemnifies health care expenses, provides or administers health care benefits, or otherwise pays or arranges for the payment of benefits for health care services.

Benefit Appeal pertains to the denial of a health care service substantially based on a finding that the particular service is excluded as a benefit under the terms and conditions of the Member’s benefit plan.

Benefit Levels. The extent or degree of service a person is entitled to receive based on his or her contract with a health plan or insurer.

Benefit Package. (1) Services an insurer, government agency, health plan or employer offers under the terms of a contract. (2) The list of Covered Services an insurance plan offers to a group or individual.

Benefit Period. The maximum length of time for which benefits will be paid.

Benefits. The types of care or services an insurance plan will pay for certain types of medical care.

Benefit Substitution. An alternative treatment plan for a Member under case management that may include medical services not covered under the Member’s Benefit Agreement. If approved by Anthem, the alternative benefit is offered in lieu of a standard benefit under the Member’s Benefit Agreement.

Blue Cross Blue Shield Association (The Association).

BlueCard® Program. 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.

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

Business Partner. An entity involved directly or indirectly with Anthem. For example, software vendors may act as business partners. They provide applications to Providers to send EDI transactions and may, or may not, directly exchange transactions with Anthem. (See Trading Partner.)

Capitation. A prepaid PMPM age/sex and plan adjusted rate paid to PMG for providing Covered Services

Carelon Medical Benefits Management. As of March 2023, American Imaging Management (AIM) is now Carelon Medical Benefits Management, a leading specialty benefit management company.

Case Management Program. A program that assesses the Member's medical needs. It includes working with the PMG/IPA and other participating physicians, Hospitals, Facilities, or other health care professionals to explore and coordinate treatment alternatives that may:

1. Increase Member satisfaction
2. Achieve benefit savings
3. Result in better medical outcomes
4. Be more cost-effective

Chemical Dependency Disorders. See **Substance-Related and Addictive Disorders**.

Centers of Medical Excellence (CME) Network – Providers. The health care network that has contracts with Anthem and/or one or more of its affiliates, pursuant to which those Providers have agreed to participate in a transplant program or other designated specialty program that is to be conducted pursuant to the Member's Benefit Agreements. Refer to *Anthem Centers of Medical Excellence – Contract Operations Manual For Transplant Program.*

Centers of Medical Excellence (CME) – Facilities. Anthem has a CME network of transplant Facilities to provide services for specified organ transplants, which may include heart, liver, lung, heart-lung, kidney- pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures. These procedures may be covered only at a CME-contracting Facility. Refer to a *Blue Cross PPO (Prudent Buyer Plan) Directory* for a listing of these Facilities.

Anthem has a network of bariatric CMEs to provide medically necessary surgery for treatment of morbid obesity. Bariatric surgeries, such as gastric bypass, are covered only at a CME-contracting Facility.

Certified Nurse Midwife. These health care professionals may perform the following services:

- Family planning
- Prenatal care
- Postnatal care
- Normal delivery
- Routine newborn care

Chiropractic Services. Practitioners who treat neuromusculoskeletal disorders, using manipulation and therapy for spinal and joint adjustments. Anthem contracts with American Specialty Health Network (ASHN) to access their network of participating chiropractors.

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

Clinical Laboratory. Health care professionals, who collect, test and evaluate specimens (i.e., hematology, immunology, cytology, histology and microbiology).

Continuous Care. Means the hospice nursing care needed on a continuous basis, for a minimum of eight hours a day, during a period crisis, in order to maintain a terminally ill patient at home through palliation or management of the patient's acute medical symptoms.

Coordination of Benefits. A specific method of determining primary responsibility for paying Covered Services under the terms of the applicable Benefit Agreement or insurance policy, and applicable law and regulations, when more than one payor may have liability for payment for services received by a Member.

For the purpose of the *Prudent Buyer Plan Participating Physician Agreement*, coordination of benefits may include various non-duplication arrangements, in addition to traditional coordination of benefits provisions found in group insurance policies.

Course of Treatment. The period of time that a Member receives therapeutic or rehabilitative treatment of a mental disorder or chemical dependency. A course of treatment: 1) begins on the day the Member starts the treatment; 2) runs continuously through the day the Member is discharged from, or voluntarily leaves, the inpatient treatment Facility or outpatient treatment care center; and 3) will be considered completed, provided the treatment has continued for the number of days prescribed by the medical director of an inpatient treatment Facility or outpatient day treatment center, and accepted by Anthem for treatment of the chemical dependency or mental disorder. **Note:** all Facilities should ensure that an appointment has been scheduled for the Member before the Member is discharged from the Facility. This appointment should happen within seven days of discharge.

Covered Services. Medically necessary services or supplies for which benefits are offered in the Member's Evidence of Coverage (EOC).

Credentialing. The review and verification process used to determine the current clinical competence of a Provider and whether the Provider meets the managed care organization's pre-established criteria for participation in the network.

Crossover. The ability to forward claims to the secondary payer after the Claim has been processed by the primary payer. Also known as **Coordination of Benefits.**

Custodial Care. Care provided primarily to assist the Member in daily living activities. This includes help in walking, getting in and out of bed, bathing or dressing. It also includes preparing food or special diets, feeding, administering medicine that is usually self-administered, or any other care not requiring the continued attention of trained medical or paramedical personnel.

Detoxification. The medical supervision of withdrawal from alcohol and/or drugs to which a patient was addicted or habituated. These substances do not include tobacco or food substances. Detoxification must require active medical supervision of a brief, protocol-specific substance withdrawal program.

Detoxification may occur in a 24-hour Facility or on an outpatient basis, depending upon severity and medical necessity according to the patient's condition and circumstances.

Diagnostic Imaging. Health care professionals who perform radiological procedures, such as X-rays, computerized axial tomography (CAT) scans and magnetic resonance imaging (MRI) scans.

Dialysis Facility. Freestanding renal dialysis facilities provide services for hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis and other miscellaneous dialysis services.

Disease Management. A coordinated system of preventive, diagnostic and therapeutic measures intended to provide cost-effective, quality health care for a patient population who have, or are at risk for, a specific chronic illness or medical condition. Also known as disease state management.

Document Control Number (DCN). A number that is assigned to each Claim for reference and payment purposes.

EDI (Electronic Data Interchange). Computer-to-computer transfer of transactions and information. Anthem Providers may use EDI for submitting claims, receiving ERAs, verifying benefits, eligibility, Claim status inquiries, and more.

ERA (Electronic Remittance Advice). Allows Providers the option to print or to automatically post payments utilizing their practice management software.

Emergency. A sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, severe pain); such that the patient may reasonably believe that the absence of immediate medical attention could result in any of the following:

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions
3. Other serious medical or psychiatric consequences
4. Serious and/or permanent dysfunction of any bodily organ or part

Extension of Benefits. Extended benefits that may be available to Members who are totally disabled on the termination date of their Benefit Agreement. Extended benefits have the meaning set forth in the Benefit Agreement applicable to the Member.

Follow-Up Care. Care that is provided to the Member after the initial medical emergency service.

G&A Staff and Scope of Responsibility. G&A is comprised of a team of board-certified physicians (medical directors), nurses, behavioral health clinicians, and G&A analysts and Behavioral Health (BH) coordinators trained in the G&A process. The G&A team is charged with resolving Member grievances and appeals through an equitable, timely and consistent process, and communicating resolutions in a clear, concise manner.

Grievance. Is a written or oral expression of dissatisfaction regarding the plan and/or Provider, including quality-of-care concerns, quality of service concerns, and shall include a complaint, dispute, request for reconsideration, or appeal made by a Member or the Member's representative. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Grievances and Appeals Clinical. Staff includes licensed nurses and licensed behavioral health clinicians, who coordinate the review and investigation of clinical grievances.

Grievances and Appeals Analysts. Non-clinical staff responsible for the review and resolution of administrative aspects of grievances and appeals.

Grievances and Appeals Clinical Associates, Behavioral Health Clinicians and an Audit Team handle special projects and tasks including, but not limited to, the following:

- Investigating and responding to Member regulatory complaints, and regulators' request for information/records to facilitate the Independent Medical Review (IMR) process
- Training and mentoring G&A associates on all aspects of the grievance and appeals process, including changes in regulatory and accreditation standards as applicable, and correct usage of the G&A database documentation system.
- Ensuring that G&A policies and procedures are compliant with regulatory and accreditation standards, and educating staff of any policy changes that affect the processing of grievances/appeals
- Internal audits of G&A cases to ensure compliance
- Coordination of review of cases referred to the Anthem Blue Cross Peer Review or Credentialing Committees and recording minutes of the meetings
- Trend analysis of grievances and reporting results to the designated medical director

Hemodialysis Services. Services rendered by a Medicare-certified hemodialysis Facility. Hemodialysis services include Facility charges, using Facility equipment and supplies, laboratory tests, and drugs administered in conjunction with on-site treatment.

Health Care Professional. Any of the following: doctor of medicine or osteopathy who is licensed to practice medicine or osteopathy where the care is received, or audiologist, chiropractor, clinical psychologist, clinical social worker, dentist, marriage and family therapist, nurse midwife, nurse practitioner, occupational therapist, optometrist, physical therapist, physician assistant, podiatrist, registered nurse, and/or speech pathologist providing services within the scope of practice, as defined by the appropriate clinical license and/or regulatory board

Health Maintenance Organization (HMO). A prepaid plan program that provides or arranges for health services to its Members on a prepaid, monthly basis (i.e., capitation).

Home HMO. The participating plan in which an HMO-USA participating plan Member is enrolled.

Home Health Agency. The following services are provided by a Home Health Agency (HHA):

1. Skilled nursing services
2. Post partum nurse
3. Licensed vocational nurse
4. Services of a licensed therapist for physical, occupational, respiratory or speech therapy
5. Services of a medical social worker
6. Services of a home health aide
7. Medically Necessary supplies

Home Infusion Therapy (HIT). Pharmacies that provide pharmaceuticals, supplies and equipment for infusing medication, such as antibiotics, chemotherapy, total parenteral nutrition, pain management and other infusion therapies in the home.

Hospice. A hospice provides palliative care for terminally ill patients.

Hospice Care. An approach to treatment that recognizes the impending death of an individual warrants a change in focus from curative care to palliative care (relief of pain and other uncomfortable symptoms). The goal of hospice care is to help terminally ill individuals continue life with minimal

disruption to normal activities, while remaining primarily in the home environment. It includes routine care, continuous care, respite care and inpatient hospice care.

Hospitals. Among Anthem's participating Hospitals are preferred participating Hospitals. These preferred Hospitals are afforded several operational advantages, as described in the Member's Benefit Agreement. To find out if a Hospital is a preferred participating Hospital, call the Customer Service telephone number on the Members' health care identification (HCID) card.

Hospital/Facility Services. Hospital/Facility services means those acute care inpatient, residential, rehabilitation and Hospital day treatment outpatient services that are covered by a Benefit Agreement, providing coverage for mental or nervous disorders, psychiatric disorders or substance abuse. Hospital/Facility services do not include long-term non-acute care.

ICD-10 (International Classification of Diseases, 10th Revision). ICD-10 Procedures and Diagnosis codes.

Independent Practice Association (IPA) and Participating Medical Group (PMG). A legal entity organized under the laws of the state of California that operates under a contract with Anthem to provide and arrange for professional health services to persons who are enrolled in Anthem Blue Cross commercial HMO plans.

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

Initial Request/Continued Stay Review (continuation of services). Review for medical necessity during initial/ongoing inpatient stay in a Facility (hospital) or a course of treatment, including review for transitions of care and discharge planning.

In-Network Utilization Factor. The quotient of the baseline professional capitation payment, divided by the sum of the baseline professional capitation payments, plus expenses for out-of-network services, modified each calendar quarter to allow for incurred, but not reported, expenses (IBNRs) based on Anthem

Blue Cross' overall Anthem POS experience, as follows:

> Baseline Professional Capitation Payment = A
> Expenses for Out-of-Network Services = B (Modified to allow for IBNRs)
> In-Network Utilization Factor = C
> A ÷ (A+B) = C

Inpatient Hospital Services. Services that include inpatient hospital days for semiprivate accommodations, special treatment units, or private room accommodations, if specifically authorized as Medically Necessary by a PMG/IPA.

Inpatient Hospice Care. Means an inpatient stay necessary to manage acute symptoms, such as uncontrolled pain, severe respiratory distress, hemorrhaging, intractable nausea/vomiting, severe dysfunction, unmanageable behavior, seizures and acute distress, in the actively dying phase. Inpatient hospice care is provided in a Provider-owned or contracted SNF or Hospital and includes, but is not limited to, room and board, nursing care and hospice services.

Intake Representative. Nonclinical Anthem staff who obtain nonclinical and structured clinical information about Members by telephone, FAX, or other electronic means of submission at the time of the request for prior authorization of service or notification of a Member's admission to the Hospital.

Intensive Outpatient Program. A program having organized and structured services that are provided for no less than three hours a day, but usually no more than five hours a day, at least three times per week. The Member should reside in a community setting while receiving intensive outpatient program services and is not in a 24-hour residential treatment setting. With symptom improvement, a gradual decrease in services per week may occur. Components of treatment should include a comprehensive clinical assessment, a psychiatric evaluation upon admission and upon follow up as needed, individual therapy, family therapy, group psychotherapy, psycho-educational groups, skills training, and expressive/activity therapies. For Substance Use Disorder Intensive Outpatient Programs, there should be an evaluation for medication that may improve the Member's ability to remain abstinent or reduce substance use. Treatment should include attendance at community-based recovery programs, drug screens as clinically appropriate, and family involvement in treatment.

Interactive Voice Response (IVR). The Interactive Voice Response unit is an automated computer system that stores and relays the eligibility, benefits and Claims data for a Member.

Intermittent Care. Care provided for periods of time less than two hours in duration and not more than one time per discipline per 24-hour period, unless preauthorized as Medically Necessary by Anthem.

Involuntary Member Transfer. Consists of the Member's reassignment to a PMG other than the one chosen by the Member, with or without the Member's consent.

Life-Threatening. Means either or both of the following:

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

Managed Care Network. The network of health care professionals who enter into contracts with Anthem and/or one or more of its affiliates. Health care practitioners agree to participate in the Anthem programs that are conducted pursuant to Benefit Agreements.

Medical Advisor. A validly licensed physician or other medical expert (e.g., physical therapist, psychologist or licensed clinical social worker) who is employed by, or under contract with, a review organization to carry out utilization reviews.

Medical Provider Network (MPN). A network of Providers, including physicians, created to provide medical treatment for work injuries of employees in California. Self-insured employers or workers' compensation insurers may have an MPN. Under SB 863, an entity providing physician network services can also have an MPN. An MPN must be approved by the California Division of Workers' Compensation (DWC) before it can be used. Unless exempted by law or the employer, all medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN.

Medical Products and Services. The medical products and services network includes the following:

1. Medical supplies
2. Orthotic appliances
3. Prosthetic devices and services
4. Hearing aids
5. Oxygen equipment and supplies

Medically Necessary. Procedures, supplies, equipment or services that Anthem determines to be:

1. Appropriate for the medical condition symptoms, diagnosis or treatment
2. Provided for the medical condition diagnosis or direct care and treatment
3. Within standards of good medical practice, within the organized medical community; and
4. Not primarily for the convenience of the Member's physician or another Provider; and
5. The most appropriate procedures, supplies, equipment or services that can safely be provided. The most appropriate procedures, supplies, equipment or services must satisfy the following criteria:
    a) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Member with the particular medical condition being treated more than other alternatives;
    b) generally accepted treatment forms that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the Member is receiving or the medical condition's severity and safe and adequate care cannot be received by the Member as an outpatient or in a less intensified medical setting.

Medicare Advantage Plan. A plan offered by a private company that contracts with Medicare to provide Medicare beneficiaries with all their Medicare Part A and Part B benefits. Medicare Advantage plans are HMOs, PPOs, or Private Fee-for-service plans. If a beneficiary is enrolled in a Medicare Advantage plan, Medicare services are covered through the plan, and are not paid for under Original Medicare.

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

Medicare Prescription Drug Plan. A stand-alone drug plan, offered by insurers and other private companies to Medicare beneficiaries that receive their Medicare Part A and/or B benefits through Original Medicare; Medicare Private Fee-for-service plans that don't offer prescription drug coverage; and Medicare cost plans offering Medicare prescription drug coverage.

Member Months. A count that records one Member month for each month the Member is enrolled in the Anthem HMO or POS Program.

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

Any condition meeting this definition is a mental or nervous disorder, no matter what the cause of the condition may be; but, medical conditions that are caused by Member behaviors that may be associated with these mental conditions (e.g., self-inflicted injuries and treatment for severe mental

disorders) are not subject to the below limitations. One or more of these conditions may be specifically excluded under a Member's plan.

Anthem pays for the following for Covered Services provided under the Member's Benefit Agreement:

1. The same inpatient services as those provided for any other condition, subject to any limitations applicable to the treatment of mental disorders
2. Any additional inpatient services needed for detoxification during acute withdrawal from alcohol or other drugs

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

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

Medically Necessary marriage, family, or group counseling is covered, subject to the terms of the applicable Benefit Agreement. Each Member attending the session is responsible for his or her own copayment, and each session counts as a visit toward that Member's visit maximum.

Mental Health Parity (MHP). Coverage in a plan for mental health (MH) and/or substance abuse (SA) benefits provided at "parity" or equal coverage with the medical and surgical benefits in the same plan.

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

Newborn. A baby less than 31 days old.

Non-Clean Claims. A Claim that has a defect or impropriety. A non-clean Claim lacks substantiating documentation required from an outside source, or has a particular circumstance requiring special treatment that prevents timely payment being made.

Non-capitated Expenses. The actual expenses incurred to provide non-capitated services to Members, as ordered, authorized or referred by PMG physicians.

Non-capitated Services. The services designated in the *Anthem Blue Cross HMO Medical Services Agreement*.

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

Nonparticipating Hospital. A Hospital that has not entered into a written Agreement with Anthem to provide medical services to Members for prospectively determined rates.

Nonparticipating Provider. A health care professional who has not entered into a written Agreement with Anthem to provide medical services to Members for prospectively determined rates.

Norms. Numerical or statistical measures of observed performance of health care services, derived from aggregated information related to the health care services provided to a statistically significant number of persons, as developed by a review organization.

Occupational Medicine Network. An Anthem health care delivery network that provides health services to injured workers covered by an insured or self-insured Workers' Compensation plan.

Occupational Therapy. Health care Providers specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Other Payors. Anthem has network leasing arrangements with a variety of organizations including, but not limited to, Insurers, Self Insured Employers, and Third Party Administrators that are responsible for payment of benefits, which Anthem calls "other payors". Other payors and affiliates use the Anthem network for Members and as such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing.

Refer to **Other Payors (Network Leasing Arrangements),** in this Manual.

Out-of-Area Emergency Services. Emergency services that are rendered to a Member beyond a certain distance from the PMG medical offices or the satellite Facility to which the Member is assigned. When the PMG is organized as an IPA, out-of-area emergency services are those emergency services that are rendered to a Member:

For HMO plans, at a distance of more than a twenty (20)-mile radius from a Hospital designated in the *Anthem Blue Cross HMO Medical Services Agreement* as a service area Hospital.

Check the contract for verification and details.

Out-of-area emergency services also include out-of-area services urgently needed to prevent serious deterioration of a Member's health resulting from unforeseen illness or injury, for which treatment cannot be delayed until the Member returns to the service area.

Out-of-Network Services. Those services that are rendered to Anthem POS Members by a nonparticipating physician or other health care professional and would be professional capitation services if rendered by the PMG under the agreement to Anthem HMO Members, except for out-of-area emergency and urgent care services.

Outpatient Hospital Services. Services that include the Facility component of outpatient surgery, pre- admission testing and laboratory and radiology services.

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

Out-of-pocket Maximum. Refers to the maximum amount that an insured employee will have to pay for expenses covered under the plan. It is a sum of deductible and coinsurance amounts.

Outpatient Day Treatment. See below: *Partial Hospitalization Program***.**

Parity Benefits. Coverage for mental health and/or substance abuse conditions provided on par with medical benefits. Currently mandated by many states and the federal legislation.

Partial Hospitalization Program. Partial hospitalization is a structured, short-term treatment modality that offers treatment in a program at a minimum of six hours per day, five days per week for Members who are able to function in the community at a minimally appropriate level and do not present as an imminent potential for harm to themselves or others. The Member should reside in a community setting while receiving partial Hospital program services and is not in a twenty-four (24)-hour

residential treatment setting. With symptom improvement, a gradual decrease in services per week may occur. Components of treatment should include a comprehensive clinical assessment, a psychiatric evaluation upon admission, at least weekly psychiatric follow up visits, individual therapy, family therapy, group psychotherapy, psycho-educational groups, skills training, and expressive/activity therapies. For Substance Use Disorder Partial Hospital Programs, there should be an evaluation for medication that may improve the Member's ability to remain abstinent or reduce substance use. Treatment should include attendance at community-based recovery programs, drug screens as clinically appropriate, and family involvement in treatment.

Participating Hospital. A Hospital that has an agreement to provide Hospital services as a participating Facility.

Participating Medical Group (PMG). A group of physicians who have an agreement with Anthem Blue Cross to furnish medical services to Anthem HMO Members.

Participating Medical Group Physician. A physician who has an agreement with Anthem to provide medical services as a participating physician, and is a licensee as that term is defined in *California Business and Professions Code Section 2041.*

Participating Physician. A physician who has a written Agreement to provide medical services as a participating health care professional and who is a "licensee," as that term is defined in the *Business and Professions Code, Section 2041*.

Participating Provider. A Hospital, other health care Facility, physician, IPA, PMG or medical group, or other health care professional that has entered into an Agreement with Anthem to provide health care services at prospectively determined rates. A participating Provider may also be referred to as a "Contracted Provider" or an "In-Network Provider".

Patient Stabilization. A patient is stabilized or stabilization has occurred when, in the opinion of the treating physician and/or surgeon, or other appropriate licensed persons acting within their scope of licensure under the supervision of a treating physician and/or surgeon, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, the release or transfer of the patient.

Peer Clinical Reviewers (PCRs). Health care professionals with current and active unrestricted licenses to practice medicine and are board certified by a specialty board approved by the American Board of Medical Specialists (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctor of osteopathic medicine). PCRs who participate in the review of clinical appeals must be in the same or similar specialty that typically manages the medical condition, procedure or treatment under review. They render expert opinions and recommendations on clinical issues.

Per Diem. A fixed payment measure for a day of service.

Physical Therapy. Health care Providers specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Policy(ies). A written Agreement entered into by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) and groups or individuals under which Anthem Blue Cross Life and Health indemnifies health care benefits, including, but not limited to: Anthem Blue Cross Life and Health PPO plans, fee-for-service plans, BC PPO (non-California resident) plans and other Anthem Blue Cross Life and Health plans.

Pre-certification. Review for medical necessity prior to service delivery. Some common synonyms: pre- service, preauthorization and/or pre-auth. See **Authorization.**

Preferred Provider Plan or PPO Plan. A Benefit Agreement in which Members have a financial incentive to use participating health care professionals, including, but not limited to, a *Prudent Buyer Plan Benefit Agreement*.

Pre-service Review. Review for medical necessity that is conducted on a health care service or supply prior to its delivery to the Member.

Preventive Care Center. A preventive care center is a participating Hospital that has an Agreement to provide preventive services to Anthem Members. Qualified health care professionals, under the supervision of a physician, perform the following services:

1. Physical exam and health history
2. Computerized health inventory assessment
3. Blood pressure check
4. Non-fasting finger-stick cholesterol check for Members ages 19 and over
5. Immunizations given as standard medical practice for Members ages seven through 18, except for hepatitis B and varicella zoster; tetanus immunizations for Members ages 19 and over, if none received in previous 10 years; and influenza vaccines, when medically appropriate for Members ages 19 and over
6. Vision and hearing exams for Members ages seven through 18
7. Other medically appropriate diagnostic tests and procedures
8. Health promotion and health education counseling, videos and brochures

Primary Care Physician (PCP). A physician is a licensee, as that term is defined under the Business and Profession Code, Section 2041. A PCP is responsible for requesting authorization for, and coordinating and controlling the delivery of Covered Services to the Member. PCPs include general and family practitioners, internists, pediatricians and other such specialists as Anthem may approve to be designated PCPs.

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

Professional Capitation. A uniform prepayment fee PMPM for professional capitation services, adjusted by age/sex and based on the services listed in the *Evidence of Coverage* issued to each subscriber.

Professional Capitation Services. All Anthem HMO-covered medical services that are not otherwise defined in this glossary or in the Division of Financial Responsibilities as institutional capitation services, risk-fund services or HMO-USA Away from Home Care Services.

Progressive Notification. A series of three notification letters sent to a Member detailing the cause of action and requesting that the Member work with the PMG and/or Anthem to remedy the issue within a specific timeframe. The Member is informed that failure to do so may jeopardize his/her Anthem coverage. If a Member fails to correct the issue/behavior within the timeframe specified by the first letter, the Member is sent a second notification letter. If the Member has not remedied the issue after the second letter, the case is reviewed by the Grievance & Appeal Committee and Anthem corporate counsel prior to sending a third notification letter.

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

Prudent Layperson. A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

Psychiatric Health Facility. An acute twenty-four (24)-hour Facility as defined in *California Health and Safety Code Section 1250.2*. It must be:

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

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

Quality Improvement Organization. An organization that provides an immediate review of an appeal initiated by a Medicare enrollee regarding a length of stay at a Facility, as determined by the medical group and/or PCP.

ReadyAccess. An umbrella term for the programs that offer expedited referrals – SpeedyReferral and DirectAccess.

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

Referral Services. Professional capitation services or institutional capitation services that are rendered to Members through referral, as authorized by the PMG.

Region Factors. Factors used to adjust the medical group's PMPM non-capitated expense or the medical portion of non-capitated expenses to account for cost variations across Anthem' corporate regions or across counties, as mutually agreed on by the PMG/IPA and Anthem.

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

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

Respite Care. Means short-term inpatient care provided to hospice patients, when necessary, to give the family Member or other caregiver relief from care giving responsibilities.

Routine Care. Means the intermittent care provided to hospice patients and their families by nurses, therapists, social workers, chaplains, and other health and psychological/social professionals, in order to provide hospice care where no immediate crisis intervention is needed.

Review Coordinator. A clinically experienced, licensed staff Member who reviews and may approve medical care and services as medically appropriate, using approved screening criteria and Anthem medical policy.

Same Specialist. Refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal.

Satellite Facility. A medical Facility, separate from the PMG's principal place of business, which is dependent on, and responsible to, the PMG. It is a Facility that meets the Anthem HMO Satellite criteria for HMO plans, as set forth in this Manual, and was approved by Anthem.

Seriously Debilitating. Diseases or conditions that cause major irreversible morbidity.

Service Area. For HMO, the geographic area within a 20-mile radius of the PMG medical offices or any satellite Facility to which the Member is assigned or, in the case of an IPA, the medical office of the PMG physician. Designating a particular geographical area will not be construed as giving a PMG an exclusive right to that service area.

Severe Mental Disorders. Severe mental disorders include the following psychiatric diagnoses in *California Health and Safety Code Section 1374.72*: schizophrenia, schizo-affective disorder, bipolar disorder, major depression, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, and bulimia nervosa.

Severe mental disorders also include serious emotional disturbances of a child as indicated by the presence of one or more mental disorders as identified in the Diagnostic and Statistical Manual (DSM) of Mental Disorders, other than primary substance abuse or developmental disorder, resulting in behavior inappropriate to the child's age according to expected developmental norms. The child must also meet one (1) or more of the following criteria:

1. As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community, and is at risk of being removed from the home, or has already been removed from the home; or the mental disorder has been present for more than six months, or is likely to continue for more than one year without treatment.
2. The child is psychotic, suicidal or potentially violent.
3. The child meets special education eligibility requirements under *California law (Government Code Section 7570).*

Blue Cross prior to being designated a satellite Facility.

Screening Criteria. Those written guidelines adopted by review organization to determine medical necessity, appropriateness and length of stay.

Self-Funded. When a business funds a benefit plan from its own resources rather than purchasing insurance.

Shift Care. Means the provision of nursing services, on an hourly basis, for a longer period of time than an intermittent care visit, for the purpose of providing Medically Necessary care as ordered by the physician.

Similar Specialist. Refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

Skilled Nursing Facility (SNF). A network of freestanding, sub-acute care Facilities that provide services such as:

1. Physical, occupational and speech therapy
2. Nasogastric or gastrostomy tube feedings
3. Nursing services
4. Tracheostomy care
5. Wound care
6. Ventilator care
7. Expanded spectrum IV antibiotics

Specialty Pharmaceuticals (Specialty Medications). Can best be identified by the product characteristics. If they have some or all of the below characteristics, drugs may be defined as "specialty," thereby requiring distinct distribution processes networks and Utilization Management efforts:

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

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

Specialist. A physician who is not a general practitioner, internist, family practitioner, pediatrician, gynecologist or obstetrician. A physician who limits professional attention to a particular specialty for study, research and/or treatment. Examples are cardiologists, dermatologists and neurologists.

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

- Produced by recombinant DNA technology or other biological process
- Can be administered as an injection, infusion or even orally
- Targeted diseases have little or no alternative treatments

- Setting for the administration can be the home, physician's practice, outpatient clinic or another outpatient setting
- Typically target underlying disease pathology, versus merely relieving symptoms
- Higher cost per prescription than conventional therapies
- Drug toxicities and disease pathology combine to demand customized clinical monitoring and patient support
- May require temperature control or other specialty handling techniques

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

Stop-Loss Factor. The factor used to adjust the PMG's PMPM non-capitated expense to account for cost variations due to different case-managed stop-loss thresholds.

Sub-acute Care Services. Those services specified in the Agreement and covered by a Benefit Agreement.

Substance-Related and Addictive Disorders. These include substance use disorders and substance induced disorders, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM).

Subscribers. Individuals who qualified for, and are covered by, the provisions of a *Prudent Buyer Plan Benefit Agreement*.

Supplemental Professional Capitation Payment. The professional capitation payment per-Anthem Blue Cross POS Member per-month that may be earned based on the in-network utilization factor.

Surcharge. An additional fee charged to a Member for a medical service that is not approved by the applicable state regulatory authority, and is neither disclosed nor provided for in the Member's Benefit Agreement. Examples of surcharges include, but are not limited to, concierge or retainer fees, billing fees, Claim handling fees or other administrative service fees not directly related to the provision of health care services to the Member.

The Anthem Blue Cross Grievances and Appeals Officer. Has primary responsibility for the Anthem Blue Cross grievances and appeals process and monitors the operation of the system on a continuous basis to identify any emergent patterns of grievances/appeals. This individual is also responsible for ensuring compliance with reporting requirements.

The Grievances and Appeals Medical Directors. Board-certified physicians in a variety of specialties, with current and active, unrestricted medical licenses. The medical directors are responsible for clinical review, oversight and final decision-making on quality-of-care grievances, Medical Necessity and investigational appeals. The medical director or his designee making the final decision on an appeal is an individual who did not participate in any prior review and is not a subordinate of any previous reviewer and will not have participated in the initial denial. All appeals involving Medical Necessity and investigational treatment are reviewed by a peer clinical reviewer (PCR) in the same or similar specialty as the area of care under review.

Third-party Administrator. A third-party administrator (TPA) is an organization that processes insurance Claims for a separate entity. This can be viewed as "**outsourcing**" the administration of the Claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance. Often, a TPA handles the Claims processing for an **employer** that self-insures its

employees. Thus, the employer is acting as an insurance company and underwrites the **risk**. The risk of loss remains with the employer, and not with the TPA. The employer may also contract with a **reinsurer** to pay amounts in excess of a certain threshold, in order to share the risk for potential catastrophic Claims.

An insurance company may also use a TPA to manage its Claims processing, Provider networks, **utilization review**, or Membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent.

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

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

Total Eligible Billed Charges. This means the Facility's billed charges for Covered Services, except for those charges that are identified as disallowed charges in the Facility Manual.

Trading Partner. An external entity, such as a customer, clearinghouse or vendor that Providers and Facilities do business with. This relationship must be formalized with a Trading Partner Agreement.

Transfer Agreement. A written Agreement between ancillary Facilities and an acute care participating Hospital, within a reasonable distance from the ancillary Facility, to facilitate prompt transfer of patients requiring Hospital care. This Agreement includes the requirement that complete patient information be transmitted with the patient at the time of transfer.

Urgent Care Center. A Facility that meets Anthem Facility's Urgent Care Center criteria, as set forth in this Manual, and is approved by Anthem prior to being designated as an Anthem Blue Cross HMO Urgent Care Center.

Urgent Services. Urgently needed services are Covered Services (that are not emergency services as defined in this section) provided when an enrollee is temporarily absent from the health plan's service area or, if applicable, continuation area (or, under unusual and extraordinary circumstances, provided when the enrollee is in the service or continuation area, but the organization's Provider network is temporarily unavailable or inaccessible), when such services are Medically Necessary and immediately required:

1. It was a result of an unforeseen illness, injury or condition;
2. It was not reasonable given the circumstances to obtain the services through the organization offering the health plan.

Urgently needed care provided by non-plan Providers is covered when a Member is in the service area or continuation area under the unusual circumstance that the organization's Provider network is temporarily unavailable or inaccessible. Normally, if a Member needs urgent care and is in the health plan's service area or continuation area, the Member is expected to obtain care from the health plan's Providers.

Utilization Review. A function performed by Anthem to review and determine whether medical services provided, or to be provided, are Medically Necessary.

Utilization Review Reference Number. The tracking number given to a physician, Hospital, Facility or other health care professional(s) following creation of a case for review.

Well Woman Care. One visit to an OB/GYN per year for a routine gynecological examination. As of January 1, 1999, Members can self-refer to a participating OB/GYN for obstetrical and gynecological care. This routine examination includes:

Medical history

1. Physical examination
2. Breast examination, including breast self-examination instructions
3. Pelvic examination
4. Annual Pap smear
5. Mammogram
6. Standard summary of the symptoms and methods of diagnosing gynecological cancers. Existing publications from nationally recognized cancer organizations may be used. Such organizations include the National Cancer Institute and the American Cancer Society. The Medical Board of California and the California Department of Health Services are other sources of information.

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

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

Links

- **BlueCard Manual**
- **Centers of Medical Excellence**
- **Contact Us**
- **Medical Policy and Clinical UM Guidelines Link**
- **Medicare Advantage**

Exhibits

Download commonly requested forms online. Go to **anthem.com/ca.** Select **For Providers**, **under Provider Resources**, select **Forms and Guides:**

- **Advance Patient Notice Form**
- **Medicare Advantage Behavioral Health Initial Review**
- **Medicare Advantage Behavioral Health Concurrent Review**
- **Medicare Advantage Behavioral Health Discharge Note**
- **Medicare Advantage Behavioral Health Neuropsychological Testing**
- **Medicare Advantage Behavioral Health Electroconvulsive Therapy**
- **Medicare Advantage Behavioral Health Psychological Testing Request for Authorization**
- **Medicare Advantage Behavioral Health Outpatient Treatment**
- **Medicare Advantage General Precertification Request**
- **Provider Maintenance Forms**
- **Institutional Change Form**
- **Commercial Behavioral Health Forms**
- **Non-Member Donor Transplant Form**
- **Provider Dispute Resolution Request Form**
- **Facility Binding Independent Review Organization (IRO) Request**
- **Anthem Blue Cross Department Contacts Listing**
- **Claim Re-Process/Inquiry Request**
- **Member (Patient) Responsibility Agreement – Waiver Form**
- **Individual Authorization Form**

  Complete this form for release of PHI and clinical information from Provider to Company.
- **Federal Employees Plans (Member number with an R as the prefix)**
- **EAP Provider Claim Forms**

  Allows participating Employee Assistance Program (EAP) practitioners to submit an EAP Claim to Anthem Blue Cross
- **Timely Filing Acceptable Forms of Proof**