Anthem Blue Cross and Blue Shield

Connecticut Provider Manual

Effective August 1, 2024

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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,** a few key topics are:

- Digital guidelines
- Claims submission
- Reimbursement and administrative policies and requirements
- Credentialing
- 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 Provider 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 and Facility

This Manual is intended to support all entities and individuals who have executed a Provider or Facility Agreement with Anthem. The use of "Provider" within this Manual refers to entities and individuals contracted with Anthem who submit professional Claims. They may also be referred to as Professional Providers in some instances.

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

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

Capitalization

Capitalized terminology shown in this Manual is the same capitalized terminology shown in the standard Anthem Facility Agreement or standard Anthem Provider Agreement otherwise referred to in this Manual as Agreement. The provisions of 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 or email communications as required

by law. 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 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

Affiliates

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

To view a current listing of Anthem Affiliates, visit anthem.com, select **For Providers,** select **Forms and Guides** (under the Provider Resources column), if needed select **Connecticut** from menu on top right. Scroll down and select **Contracting and Updates** in the category drop-down, and select **Provider Agreement Affiliates List.**

Anthem Medical Specialty Pharmacy (CVS)

Effective September 15, 2021, CVS Specialty Pharmacy is the Anthem designated Provider of certain specialty medications administered in an outpatient setting. For Anthem Members in Commercial plans and Claims priced by Anthem for Commercial BlueCard Program Members, Facilities will be required to work with CVS Specialty to procure certain drugs that are covered through a Member's medical benefit. CVS Specialty will ship specialty drugs to the location of the Facility's choice. Facilities should continue to submit Claims for administration of the medication, but Anthem will not separately reimburse for the medication. CVS Specialty will bill Anthem for the medication, and Anthem will reimburse CVS directly. Facilities should contact CVS Specialty Dedicated Anthem Team at (877) 254-0015. Note that this requirement does not apply to Medicare Advantage, Medicaid, Medicare Supplement, or the Federal Employee Program.

Facilities can access the current CVS Specialty drug list online at **anthem.com**, Select **Forms and Guides**, select Category **Pharmacy**, select **Anthem Medical Specialty Pharmacy (MSP) CVS Drug List**. This drug list is subject to change. All drugs on the list must be procured by the ordering Provider or Facility through CVS and if the listed specialty medications are obtained through other pharmacies, Anthem will deny payment and Members should not be billed.

Clinical Data Sharing

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

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

- Clinical data for a Member on a daily, weekly, or monthly basis, in a mutually agreeable format and method based on the Provider's electronic medical record (EMR) or other electronic data sharing capabilities, e.g., industry-standard CCDA clinical data format.

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

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

For details on how to submit clinical data, review the administrative policy by visiting**anthem.com**, select **For Providers**, select **Forms and Guides** (under the Provider Resources column), if needed select **Connecticut**, then scroll down and select **Administrative Policies** in the Category drop down and select **Clinical Data Sharing**.

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

Coordination of Benefits

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

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

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 required segments for the electronic billing of Coordination of Benefit Claims. To learn more, contact the EDI vendor.

When filing Coordination of Benefits Claims on paper submission

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

Copayments and Cost Sharing

Members are responsible for the co-payment amount indicated on their ID cards. Copayments apply to home and office visits but do not apply to in-network Annual Preventative Care visits, Well-Child Care visits, or maternity care. There may be exceptions depending on the Member's contract. Except for copayments, which may be collected at the time of service or discharge, Providers and Facilities should not bill the Member for any cost-sharing amounts until he/she has received an explanation of benefits (EOB). Per the Anthem Practitioner Agreement, physician or practitioner agrees to only seek payment from a Member for a health service that is not covered under the Member's benefit plan, whether it is not covered because it is specifically excluded, is not considered medically necessary or is considered investigational, when the physician or practitioner has obtained a signed, Anthem Non-Covered Services Notification Wavier which can be found at anthem.com.

Dispute Resolution, Mediation and Arbitration

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider Agreement (the "Agreement) or the Anthem Facility Agreement (the "Agreement). All administrative procedures set forth in the Agreement and this Provider Manual shall be exhausted prior to filing an arbitration demand. The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement. 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 Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34. The parties shall confer and draft an Order Regarding Procedures for Production Format and Electronic Discovery, which shall be presented to the arbitrator or panel of arbitrators for review, approval and entry.

F. Decision of Arbitrator(s)

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

law, and if either party makes such a request, the arbitrator(s) shall issue such an award or decision setting forth the factual and legal basis for the decision.

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

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

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

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

G. Interest

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

H. Confidentiality

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

whose Claims have been at issue in the arbitration, including Administrative Services Only (ASO) groups and other Blue Plans.

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.

Healthcare Provider Performance Evaluations

Anthem has developed certain Provider evaluation and/or performance policies which includes but is not limited to:

- The information maintained by Anthem to evaluate the performance/practice of health care professionals
- The criteria against which the performance of health care professionals will be evaluated
- The process used to perform the evaluation
- The information used to evaluate the Providers performance will be shared with the Provider to the extent applicable.
- Anthem shall make available on a periodic basis and upon the request of the Provider to the extent applicable, the analysis used to evaluate the Provider's performance
- Each Provider shall be given the opportunity to discuss the unique nature of the Provider's professional patient population which may have bearing on the Provider and to work cooperatively with Anthem to improve performance

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

Locum Tenens

Locum Tenens will be allowed to provide services to Anthem Members when they meet Anthem's administrative guidelines. A Locum Tenens is a substitute physician who takes over a physician's professional practice when the physician is absent for reasons such as illness, pregnancy, extended vacation or continuing medical education. The substitute physician generally has no practice of his/her own. Locum Tenens will be required to submit information to Anthem.

Administrative Guidelines for Locum Tenens:

The participating physician or Provider who will be absent must make a request to Anthem in writing prior to the Locum Tenens providing medical services to a Member. The request should include:

- Dates of absence (the request should not exceed a six (6) month substitution period, but unusual absence circumstances may be reviewed on a case-by-case basis)
- The absent physician's tax identification and Anthem Provider number

Anthem will review the completed application and send back approval or denial of the Network/Participating Provider's request for substitute physician. After the six (6) month covering period, the substitute physician must apply to become a Network/Participating Provider, either as a Member of that group or as an individual Provider, in order to continue providing in-network medical services to Members, except as otherwise approved by Anthem.

Mental Health Parity Legislation – State of Connecticut

State of Connecticut and Federal legislation mandating parity for mental health services affects the benefits for Members. Under state law, policies are required to provide coverage of the diagnosis and treatment of mental or nervous conditions (including treatment for substance abuse) on the same basis as other Health Services covered under the Health Benefit Plan. The Plan cannot place a greater financial burden on a Member for access to this type of service than for the diagnosis or treatment of medical, surgical or other physical health conditions. Excluded from this requirement is treatment related to:

- Mental retardation
- Learning disorders
- Motor skills disorders
- Communication disorders
- Caffeine-related disorders
- Relational problems

Also excluded are additional conditions that may be a focus of clinical attention, but are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Associations "Diagnostic and Statistical Manual of Mental Disorders."

This eliminates the benefit distinction between biologically and non-biologically based diagnoses as well as the hospitalization limitations specific to behavioral health services.

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact Provider Services to report receipt of misrouted PHI.

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.

Notification of Changes

In accordance with the Participating Provider Agreement (group or solo), Network/Participating Providers are required to notify Anthem sixty (60) days in advance of any of the following:

- Any change of business address, including relocation, addition or closing of a location
- Any action taken to restrict, suspend or revoke the Provider's or group's license, accreditation or certification
- Any action to restrict, suspend or revoke the Provider's medical staff privileges
- Any action brought against the group or Provider for malpractice and the final disposition of such action by settlement or adjudication
- The termination, reduction or cancellation of the insurance coverage required under the Agreement
- Any criminal action against the group or individual Provider
- Any action to suspend, sanction, expel, or disbar the group or individual Provider under Title XVIII or Title XIX of the Social Security Act
- Any situation which might materially affect the group's or solo Provider's ability to carry out the duties under the terms of the Agreement, or to meet any credentialing/ recredentialing criteria
- For Group Agreements only: any material changes in the group's ownership to the extent that the ownership or control of the group changes by twenty (20) percent or more.

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 to improve the accuracy of provider directory information.

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

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

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

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

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

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

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 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
- open practice
    - Provider shall give Anthem sixty (60) days prior written notice when Provider no longer accepts new patients, so that Anthem may maintain current information on Provider availability in the online Find Care directories.

Submitting Demographic Data Requests and Roster Submissions through Roster Automation

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

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

Roster Automation is our 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.

Provider Termination Without Cause

- Anthem's participation Agreements set forth a required notification period for termination of the contract without cause on the part of Anthem or the Network/Participating Provider. In no case is the notice period less than one-hundred twenty (120) days.
- Anthem recognizes that there are situations in which Providers do not know far in advance of a pending termination but ask that Providers notify Anthem immediately as soon as this determination has been made. These situations may include:
    - Moving out of state
    - Leaving a group to accept a position with another practice
    - Illness, injury or other emergency
    - Retirement: in the case of retirement, Anthem will be firm that the Network/ Participating Provider comply with the required notice period per the terms of the contract

- The advance notice is required by Connecticut law and is for the benefit of Members. In order to satisfy Anthem's internal quality standards, as well as maintain Anthem's accreditation with the National Committee on Quality Assurance (NCQA) Anthem is required under accreditation standards to notify Members at least thirty (30) days in advance of Provider termination date, upon termination of:
    - Primary care physician selected by the Member under his/her plan with Anthem
    - Specialist who has provided services to the Member within the past twelve months (based on history of Claims submitted by the Provider)

When a network Provider is terminated from a network, Anthem will make a good faith effort to notify Members no later than thirty (30) calendar days following receipt of the written termination notice. Members who are attributed to, or have received services from the affected Provider will be notified. If a Provider notifies Anthem of termination less than thirty (30) calendar days prior to the effective date, Anthem notifies the affected Members as soon as possible and as required by law; as noted above, Anthem will make a good faith effort to provide written notice no later than thirty (30) calendar days after receipt of the notification. The Member may then call Member Services to obtain assistance in selecting a new Provider.

Provider Termination With or Without Cause – List of Participating Provider's Patients

Each participating Provider terminating from Anthem's network with or without cause, as determined by the terms of the contract, will be required to provide a list of the participating Provider's patients who are Members under a network plan of Anthem within thirty (30) days of their notification to Anthem.

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, or as required by law, rather than the non-participating Provider; and Members may be balance-billed by non-participating Providers for the difference between the amount they charge for the service and the amount paid to that non-participating Provider.

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

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements

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

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

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

Encounter Data for Risk Adjustment Purposes

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

Digital Applications

Anthem Provider Website

www.anthem.com is a public website.

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

Providers and Facilities can also sign-up for the Network eUpdates to be notified when a newsletter is published. Newsletters are designed to educate Providers, Facilities and their staff on updates and notification of changes. To sign up go to **anthem.com**, select **For Providers** and **Connecticut**, scroll down to the section **Stay Up to Date With Provider News** and select **Read the Most Recent Provider News**. On the Provider Communications webpage select the **Subscribe to Email** button on the top right side of the webpage.

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 and 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.

Accessing the Online Provider Directory

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

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 of any demographic changes. All requests must be received 60 days **prior** to change/update. Any requests received within less than 60 days' notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

IMPORTANT: If updates are not submitted 60 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 valid W-9)
- Termination of Provider Participation Agreement **
- Web Address

* To request participation for a new Provider or practitioner, even if joining an existing practice, Providers or practitioners must first begin the Application process. Go to **anthem.com**. Select **For Providers**, and under the **Join our Network** heading select the **Getting Started with Anthem** link.

**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 demographic data requests and roster submissions through Roster Automation

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

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

Roster Automation is our 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 of our Provider and Facilities:

- **Multi-payer access:** Users can access data from Anthem Medicare, Medicaid and other Commercial insurers. See **Availity.com** for a full list of payers.
- **No charge:** Anthem transactions are available at no charge to providers.
- **Standard responses:** Responses from multiple payers returned in the same format and screen layout, providing users with 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.

Digital methods of engagement include:

- **Carelon Medical Benefits Management**: Access link to precertification requests and inquiries for specific services and access the OptiNet® Survey when applicable at providerportal.com.
- **Medical Attachments:** Submit supporting documentation including medical records for initial, pended or denied claims through Availity.com. From the Claims & Payments tab, select Claim Status, submit a claim status inquiry and use the Submit Attachments link from a successful response. Use the Medical Attachments functions to submit an itemized bill electronically through the EDI 275 transaction. For providers registered in Medical Attachments through Availity.com, receive digital notifications about additional documents needed for claims processing through Digital RFAI.
- **Member Certificate Booklet:** View a local plan Member's certificate of coverage, when available

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-specific educational materials.
- **Fee Schedule:** Retrieves professional office-based contracted price information for patient services.
- **Patient360**: A robust picture of a Member's health and treatment history, including gaps in care and care reminders.
- **Preference Center:** A resource for Providers and Facilities to share correspondence preferences related to specific transactions, for example, prior authorization decision letters and PCPs patient event notifications.
- **Provider Digital RFAI Progress Dashboard:** For Providers and Facilities enrolled in Medical Attachments and using the Attachments Dashboard to receive digital notifications when additional documentation is needed to process Claims, use this Dashboard to show your organization's attachment performance.
- **Provider Enrollment:** Submit an online request to join Anthem's Provider network.
- **Provider Online Reporting**: access proprietary Provider specific reports such as Member rosters and Provider Contract and Fee Schedule notifications.
- **Remittance Inquiry**: View an imaged copy of the paper Anthem remits up to 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 (800-282-4548).

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

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

Availity Essentials Training for Anthem specific tools

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

Organization Maintenance

To update Administrator or Organization information:

- To replace the Administrator currently on record with Availity Essentials, call Availity Client Services at **1-800-AVAILITY** (**282-4548**).

- An Administrator can use the Maintain Organization feature on Availity.com to maintain the organization's demographic information, including address, phone number, tax ID, and NPI updates. Any changes made to this information automatically applies to all Users associated with the organization and affects only the registration information on Availity Essentials.

Support

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

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

Provider and Facility Digital Guidelines

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

Anthem expects Providers and Facilities will utilize digital tools, unless otherwise prohibited 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 requirements.

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, Inc.
- Services through Carelon Behavioral Health, Inc.

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

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

Providers and Facilities 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 a Provider and Facility 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 a provider 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: The Claims & Payments application enables a provider to enter a Claim directly into an online Claim form and upload supporting documentation for a defined Claim.
    - Claim Status application enables a provider 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 Claim documentation including medical records via the HL7 payload.
    - Availity Essentials – Claim Status application enables a Provider or Facility 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 your 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, contact Comdata at 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.

Electronic Data Interchange (EDI)

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

Payer IDs

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

Advantages of Electronic Data Interchange (EDI)

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

Use Availity for the following EDI transactions

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

How Providers and Facilities can efficiently use the Availity EDI Gateway

Availity EDI submission options:

- Availity EDI Clearinghouse for Direct Submitters (requires practice management or revenue cycle software)
- Use the Provider or Facility's existing clearinghouse or billing vendor. Requires the vendor to have a 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 deposit is assigned a trace number that is matched to the 835 Electronic Remittance Advice (ERA) for simple payment reconciliation.

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

You can also access EFT enrollment through our provider website at **anthem.com/provider/edi** > Select **Connecticut** > EDI Resources > Select Electronic Funds Transfer

Virtual Credit Cards (VCC)

In lieu of paper checks, providers will be issued a VCC that is processed as a credit transaction from your credit card terminal – the same terminal used for patient payments. There could be fees associated with credit card transactions based on the agreement between you and your card service provider.

VCC transactions are not as fast as EFT payments and are issued for each claim payment.

Electronic Remittance Advice (ERA) – 835

The ERA eliminates the need for paper remittance reconciliation.

Use Availity to register and manage ERA account changes:

1. Log in to Availity

2. Select **My Providers**
3. Select **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 Essentials

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

Useful EDI Documentation

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

Provider Participation

Joining Our Network

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

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

Participation Confirmation and Effective Dates

Physicians or Providers who have applied for participation should not agree to provide services as Network/Participating Providers to Members under any Anthem plan or program until such time as they receive a formal notification from Anthem that they are accepted as participating Providers. This notification will specify the effective date of participation as well as which programs and/or products are included in the participation. Providers shall not be recognized as a Network/Participating Provider until the later of: 1) the Effective Date of the Agreement or; 2) as determined by Anthem in its sole discretion, the date Provider has met the applicable credentialing requirements, standards of participation and accreditation requirements.

Any services provided to Members before the effective date will be considered as out of network services.

Standards of Participation

Anthem contracts with many types of Providers and Facilities that do not require credentialing as described in the Credentialing Program Summary available on anthem.com: **Credentialing Program Summary**.

However, to become a Network/Participating Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, and standards of participation and accreditation requirements outlined in the Provider Agreement, the chart below outlines requirements that must be met in order to be considered for contracting as a Network/Participating Provider or Facility in one of these specialties:

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

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

Notifying Members of Participation Status

Each Provider is responsible for informing Members about his/her participation status with Anthem so that Members may maximize their benefits and make informed decisions about the Providers they are choosing for their care.

Physician/Provider Access Goals and Calendar Access Requirements

One of Anthem's goals is to make accessing medical care easy for Members by assuring a comprehensive network of physicians and Providers close to their homes. As a result, Anthem has implemented the following plan-wide geographic access goals as guidelines for the HMO network. It is Anthem's goal to provide Members with access to the following within Anthem's defined service areas:

- Two PCPs within five (5) miles of each Member
- Two OB/GYNs within eight (8) miles of each Member
- Full range of specialists (including non-MD allied Providers) within fifteen (15) miles of each Member

Primary Care Providers:

- **Preventive care** – Members scheduling periodic routine exams (well care/preventive visits), appointments should be available within 45 calendar days of a Member's call. Care provided to prevent illness or injury; examples include, but are not limited to, routine physical examinations, immunizations, mammograms and pap smears.
- **Urgent care appointment with acute symptoms** – appointments should be available within 24 hours of the Member's call. Care provided for a non-emergent illness or injury with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.
- **Routine Care with symptoms** – must have access to care within 5 days of the Member's call.
- **Routine check-up** – must have access to care within ten (10) business days of the Member's call. This consists of care provided for non-symptomatic visits or follow-up.

Though it is important for Members to have the continuity of receiving care from their PCPs, there are occasions when Providers may not be available at a time that meets their scheduling needs. As a reminder, Anthem contracts with walk-in centers and urgent care Facilities, which are listed in the directory.

Specialists:

- **Urgent care appointment with acute symptoms** – appointments should be available within 24 hours of the Member's call. Care provided for a non-emergent illness or injury

with acute symptoms that require immediate care; examples include, but are not limited to, sprains, flu symptoms, minor cuts and wounds, sudden onset of stomach pain and severe, non-resolving headache.

- **Routine check-up** – must have access to care within fifteen (15) calendar days of the Member's call. Care provided for non-symptomatic visits for health check.

Behavioral Health Providers:

- **Non-life threatening emergency needs** – must be seen, or have appropriate coverage directing the Member, within six (6) hours. Emergent behavioral health care provided when a Member is in crisis, experiencing acute distress and/or other symptoms and needs immediate attention; no risk of loss of life.
- **Urgent needs** – must be seen, or have appropriate coverage directing the Member, within 48 hours. Non-emergent behavioral health illness that requires immediate care; Member is experiencing significant psychological distress with symptoms that impairs daily functioning; no risk of loss of life.
- **Initial routine office visit** – must be seen within ten (10) business days. New patient non-urgent appointment scheduled after intake assessment or a direct referral from a treating practitioner.
- **Follow-up Routine visit** – must be seen within thirty (30) calendar days. Non-urgent behavioral health care; Member has been scheduled for a non-urgent consultation or requires services including, but not limited to, follow-up and existing medication management.

24/7 Coverage Required for Network/Participating Providers

Anthem requires that Network/Participating Provider practices must afford physical or verbal Provider accessibility 24/7. Anthem recognizes that individual Providers may not be available under all circumstances for coverage of their own practices. However, when they are unavailable or when out of the office for an extended period of time, Provider(s) of a similar specialty must be covering for their patients.

After-Hours Coverage

- After-hours coverage, which is required by the Provider Agreement, consists of an attendant or recording assisting the Member in accessing urgent services outside of regular office hours. Note that telephone answering machines and voice mail are not acceptable means of providing access for Members if the answering machine or voice mail message only refers Members to the Emergency Room or to call 911. The recording or live person must refer the Member to Urgent Care Center, 911, or Emergency Room, and also provide the option to contact a live health care practitioner (via cell, pager, beeper, transfer system) , get a call back for urgent instructions, or be transferred directly to the available practitioner or on-call practitioner.
- Timely access to physicians is a major priority of Anthem Members and employer groups. The requirements adopted reflect not only their expectations, but market norms. Anthem will be assessing physicians against these requirements through customer satisfaction surveys and Provider surveys as well as follow-up on any Members' complaints received. However, Anthem is sensitive to problems related to seasonal

services, the varying nature of practice specialties, and the challenges faced by busy practices. If an office routinely exceeds these targets, it is important that Providers document and Anthem understands the reasons that the requirements are not met.

Participating Physician, Provider, and Group Agreements

Participation with Anthem is determined by completion and Anthem's formal acceptance of a Participating Provider Agreement (group or solo practice) and credentialing application. To avoid delays in compensation and gaps in participation, it is important that to contact Anthem whenever there is a change of any kind to practice information, including name, address, tax ID or other through the Provider Data Management (PDM) application on Availity Essentials.

Defining Solo vs. Group Practices

Determinations on whether a practice receives a solo or group Agreement are based on the following criteria:

- Solo Providers are identified as those who provide Anthem with a Social Security or Tax ID number (TIN) that is tied to their name alone.
- Group Providers are identified as those who provide Anthem with a TIN that is tied to either their name as a PC, LLC, or partnership; or to a group business name.

Providers who practice both as a Member of a group and under a separate practice as a solo practitioner, and are submitting the Anthem Agreement, they must sign an individual Agreement in addition to the group Agreement in order to be participating in both arrangements. A separate Agreement is required for each tax ID number under which a Provider is billing.

Moving to A New Group Practice

If a Provider, or group of Providers, leaves a participating group practice and joins or forms another group practice, participation does not automatically continue for those Providers. Depending on the situation, a new Group Agreement and/or Signature Sheet may need to be completed and submitted in order to continue participation in Anthem's networks with a new group, for example if there is a different TIN associated with the new group. Services to Members are not eligible for in-network reimbursement until such time as the physician or Provider receives a formal notification from Anthem of his/her participation under the new Group Agreement, and the effective date of same, as noted under Participation Confirmation and Effective Dates above.

Adding New Providers to Group Practices

It is important that new individual Providers joining group practices promptly apply for participation in order to maintain participation consistency within the practice and ensure that Members see Providers to maximize the value of their Health Benefit Plan. Important note: a new Provider in a participating Anthem group is not considered a Provider until such time as he/she is credentialed and/or contracted with Anthem and receives formal written notification of participation and effective date.

Participation In a Provider Sponsored Organization

In circumstances where Anthem contracts with an IPA, PHO, or other Provider-sponsored organization, Providers may be required to execute an individual or group Agreement with Anthem in addition to the Agreement with the contracting organization

Hospitalist Programs

Anthem has developed a network of contracted hospital-based hospitalist programs. The goal of these programs is to promote continuity of medical care 24/7 in the inpatient and outpatient settings for Members who elect to support the decision of their primary care physician (PCP) to have acute inpatients medical care provided to their patients through such a program.

Information to be supplied by a requesting Facility:

- An entity requesting participation for a hospitalist program must provide a detailed description of its program to Anthem
- This description must include an established communication process with primary care physicians about their patients on the hospitalist inpatient service
- A list of all current hospital-based physicians who provide clinical care through the hospitalist program, with curriculum vitae
- Name of the contracting entity and its business relationship to the hospitalists
- Identification of the billing entity for professional services rendered by the hospitalists

Requirements for participation in an Anthem Contracted Hospitalist Program:

- Hospitalists must be credentialed by the hospitals as full-time hospital employees with no community-based practices. They are not selected by Anthem Members as PCPs and are not listed in Anthem Provider directories.
- Hospitalists must have current American Board of Medical Specialty (ABMS) or American Osteopathic Association (AOA) board certification in internal medicine or family practice, or must be eligible to take the applicable certifying examination and achieve full board certification within the time period required by the applicable hospital medical staff bylaws.

Laboratory Services

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

Physician Office Lab (POL) List

Anthem will allow participating HMO, POS, PPO, and EPO network physicians to perform select laboratory services in their office. The lab services are listed on the Physician Office Lab (POL) list. The Member must be referred to a participating laboratory for lab services not included on

the POL list. Claims submitted to Anthem for laboratory services not on the POL list will be denied and the Member cannot be balance billed.

Anthem's POL list can be found at anthem.com > Forms and Guides, and the find Physician Office Lab (POL) list.

Member Eligibility

Facilities and Providers may identify and verify benefits for Members by using the following resources:

- **Availity Essentials** (see description above)
- **Provider Service Centers:** Contact the appropriate service center using the information provided on the back of the Member's ID card or by referring to the appropriate service center listed under Contact Us on anthem.com Provider page or by selecting this link: **Contact Us.**

Alpha Prefix Information

The three-character alpha prefix at the beginning of the Member's identification number is the key element used to identify and correctly route out-of-area Claims. The alpha prefix identifies the BCBS Plan or national account to which the Member belongs. It is critical for confirming a patient's membership and coverage.

Some identification cards with a BlueCard suitcase may not have an alpha prefix. This may indicate that the Claims are handled outside the BlueCard program. Look for instructions or a telephone number on the back of the card for information on how to file these Claims.

Occasionally, Providers and Facilities may see identification cards from foreign BCBS Plan Members. These identification cards will also contain three-character alpha prefixes. Treat these Members the same as domestic BCBS Plan Members.

Suitcase Logos

To provide the visual symbol that physicians and Facilities need to identify PPO Members, ID cards with the PPO logo for those Members who have BlueCard PPO or BlueCard EPO benefits have been created. The logo, shown below, must appear on the face of the card. A "PPO" in a suitcase logo means that the patient has a PPO program.

Remember: Not all PPO Members are BlueCard PPO Members, only those whose membership cards carry this logo are part of the BlueCard PPO Plan.

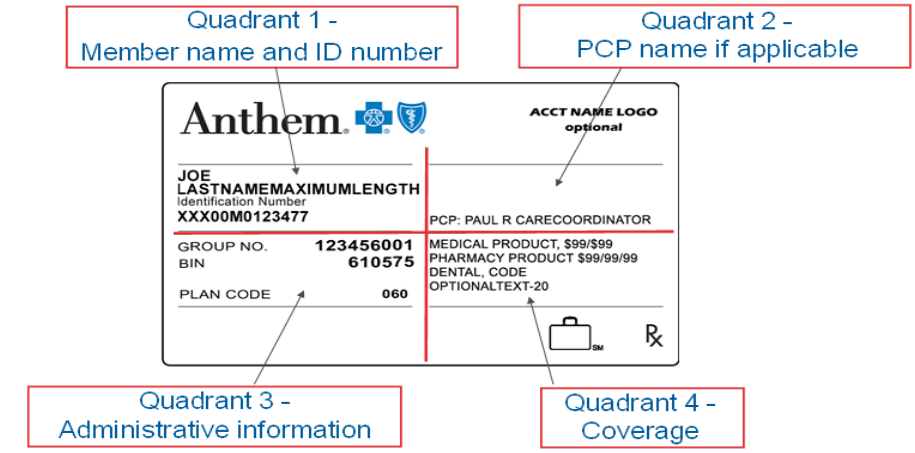
To identify all other BlueCard Members, except for those with Medigap coverage, that do not have BlueCard PPO, the blank (empty) suitcase logo is included on the face of the card. The

blank suitcase, in conjunction with the alpha prefix, will communicate to Providers how to process Member Claims. A blank suitcase logo on a Member's identification card means that the patient has a Traditional (Indemnity), POS, or HMO product.

Member Identification Card

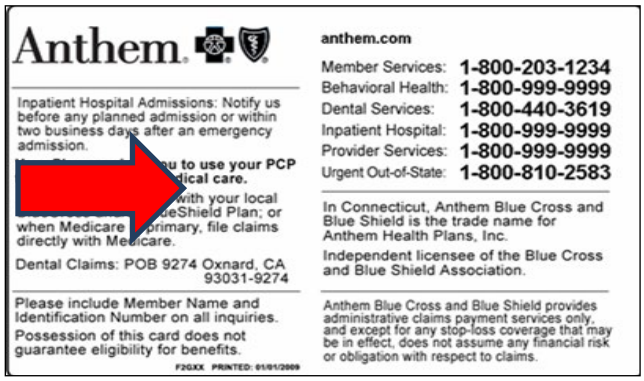
Ask Members for the most current ID card at every visit and submit Claims with ID numbers exactly as they appear on a Member's ID card including alpha prefixes.

Identification Card Front



Identification Card Back

- Anthem Logo is included for easy reference when only ID card back is copied
- All contact information is in the upper right corner
- PCP text appears on HMO and POS ID cards



CT Insurance Exchange Plans (Pathway Network) – Member ID Cards

Members purchasing plans under the Connecticut Insurance Exchange (Pathway) receive new Member ID cards. The Pathway ID cards have a similar format to commercial Anthem Member

ID cards, but some information on the card may look slightly different. This information is critical, as it provides details about Member benefits and the Provider network supporting the Member's health plan. For example, some new plans have limited or no out-of-area benefits.

Claims Submission

General Guidelines

To facilitate Claims processing, all Claims must:

- Be either the uniform bill Claim form or electronic Claim form in the format prescribed by Anthem
- Be submitted by a Provider for payment by Anthem for Health Services rendered to a Covered Member
- Be considered to be a Complete Claim which means, unless state law otherwise requires, must contain all information necessary to process the Claim and make a benefit determination

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 EDI Submissions 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/provider/edi/companion-guide. Select Connecticut** from the dropdown list and **enter**. Select **Companion Guide > Review the Guide**, then see the appropriate link under the *Section B – Transaction Specific Companion Documents* heading.

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

Claim Submission Filing Tips

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

Ambulatory Surgical Centers

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

Ancillary Filing Guidelines

Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- Ground or Independently contracted ambulance providers should file the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- Air Ambulance providers contracted through a facility 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 81.
- Unless exempted by state or other legal guidelines, Anthem requires the CLIA number to be included on each Claim billed for laboratory services by any Provider or Facility performing tests covered by CLIA. Anthem requires the CLIA identification number to be submitted based on the applicable method below:
    - ASC X12 837 professional Claim format REF segment as REF02, with qualifier of "X4" in REF01 or
    - Field 23 of the paper CMS-1500

Specialty Pharmacy Claims

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

CPT Coding

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

Duplicate Claims

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims through Availity. 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 at **anthem.com/edi**). Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a five (5) in the third position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. Providers and Facilities should also advise the original Claim # to which the late charges should be added.

Maternity Delivery Claims

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

National Drug Codes (NDC)

See separate subsection titled *National Drug Codes*.

Negative Charges

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

Not Otherwise Classified (NOC) Codes

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

- If the NOC is for a drug, include the drug's name, dosage NDC number and number of units.
- If the NOC is not a drug, include a specific description of the procedure, service or item.
- If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.

- If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
- If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

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

Occurrence Dates

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

Other Insurance Coverage

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

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 and Facility will bill for the CPT code with an

ICD-10 diagnosis code corresponding to the pathology found rather than the “Special screening for malignant neoplasms, of the colon.”

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

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

Type of Billing Codes

When billing Facility Claims, ensure that 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.

Frequency Codes

When submitting frequency codes (third digit of type of bill (TOB) on a UB-04 electronic Claims (837I), keep in mind the following guidelines:

- Frequency 5 (TOB example 135) is used to resubmit late charges. Claim(s) received in the 837 HIPPA Claim format with a 5 as the third digit in the TOB field will be identified as a Claim with added lines or late charges.
- Frequency 7 (TOB example 117) is used to replace a prior submitted Claim. This frequency code is used as a full replacement of a prior submitted Claim.
- Frequency 8 (TOB example 138) is used to void/cancel a prior Claim. Frequency code 8 is to be used when a void (void/cancel of a prior Claim) is being requested.

Be sure to send the original Claim number when available for all types of frequency codes.

Facility Charge updates during an Inpatient Stay

When a Facility’s charges are updated during an inpatient stay the Facility should bill each set of days using the appropriate revenue code on the UB 04. One line should indicate the days prior to the Facility Charge Update and a second line should be billed indicating those **charges from the date of update and after.**

Emergency Room Billing Guidelines

Occasionally, a Covered Individual may require two (2) visits to the emergency room on the same day at the same Facility. Even though both Claims would have different patient control numbers, one Claim will automatically deny as duplicate to the other Claim. To help us identify Claims that are not duplicates, include the admit hour (form locator 13) and the discharge hour (form locator 16).

Filing Tips for Contiguous Border County Providers

Providers practicing in a county bordering another state and having contracts with Blue Plans in their home state and the neighboring state should file all Claims with the local Blue Plan, based on where they provided the service, except when a Member has coverage with the neighboring state’s Blue Plan.

Claim Inquiry/Adjustment Filing Tips

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

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

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

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

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

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

- **Pre-certification Disputes:** Pre-certification disputes should be handled via the process detailed in the letter received from the Utilization management (UM) 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 pre-certification 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 ninety (90) days from the date of service or discharge, or in accordance with the timely filing timeframe specified in the Provider or Facility Agreement. All additional information reasonably required by Anthem to verify and confirm the services and

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

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

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

Acceptable documentation includes the following:

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

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

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

Corrected Claim Guidance

When submitting a correction to a previously submitted Claim, submit the entire Claim as a replacement Claim if Providers or Facilities have omitted charges or changed Claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a Claim that was billed to Anthem in error, submit the entire Claim as a void/cancel of prior Claim If there is a zero (0) Member, Provider or Facility liability, then a new Claim is needed instead of a corrected Claim.

Regarding paper claims

Claims originally filed on paper are accessible through Availity.com. Submit replacement, void/cancel claims through Availity.com following the instructions below for digital submission.

Do not use the paper submission process unless there is a specific reason for filing a paper claim correction.

Type	Professional Claim	Institutional Claim
EDI	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7	**To indicate the Claim is a replacement Claim:** • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In Segment "REF – Payer Claim Control Number" • Use F8 in REF01 and list the original payer Claim number is REF02	**To confirm the Claim which is being replaced:** • In Segment "REF – Payer Claim Control Number" • Use F8 in 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.

Type	Professional Claim	Institutional Claim
Paper	**To indicate the Claim is a replacement Claim:** • In Item Number 22: “Resubmission and/or Original Reference Number” • Use Claim Frequency Type 7 under “Resubmission Code”	**To indicate the Claim is a replacement Claim:** • In Form Locator 04: “Type of Bill” • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced: • In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the resubmitted Claim.	**To confirm the Claim which is being replaced:** • In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the resubmitted Claim.
	To indicate the Claim is a void/cancel of a prior Claim: • In Item Number 22: “Resubmission and/or Original Reference Number” • Use Claim Frequency Type 8 under “Resubmission Code”	**To indicate the Claim is a void/cancel of a prior Claim:** • In Form Locator 04: “Type of Bill” • Use Claim Frequency Type 8
	To confirm the Claim which is being void/cancelled: • In the right-hand side of Item Number 22 under “Original Ref. No.” list the original payer Claim number for the void/cancelled Claim.	**To confirm the Claim which is being void/cancelled:** • In Form Locator 64: “Document Control Number (DCN)” list the original payer Claim number for the void/cancelled Claim.

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

National Drug Codes (NDC)

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

Line items on a Claim regarding drugs administered in a physician office or outpatient Facility setting for all drug categories should include the following:

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

Unit of Measurement Requirements

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

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

Location of the NDC

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

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

Correcting Omission of a Leading Zero

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

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

See the examples that follow:

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

Process for Multiple NDC numbers for Single HCPC Codes

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

How/Where to Place the NDC on a Claim Form

837 Reporting Fields

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

Loop	Segment	Element Name	Information	Sample
2410	LIN02	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	LIN03	Product or Service ID	Enter the NDC	LIN**N4***01234567891*~
2410	CTP04	Quantity	Enter quantity billed	CTP****2*UN~
2410	CTP05-1	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International unit	CTP****2***UN*~

Loop	Segment	Element Name	Information	Sample
			GR: Gram ML: Milliliter UN: Unit ME: Milligram	
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.

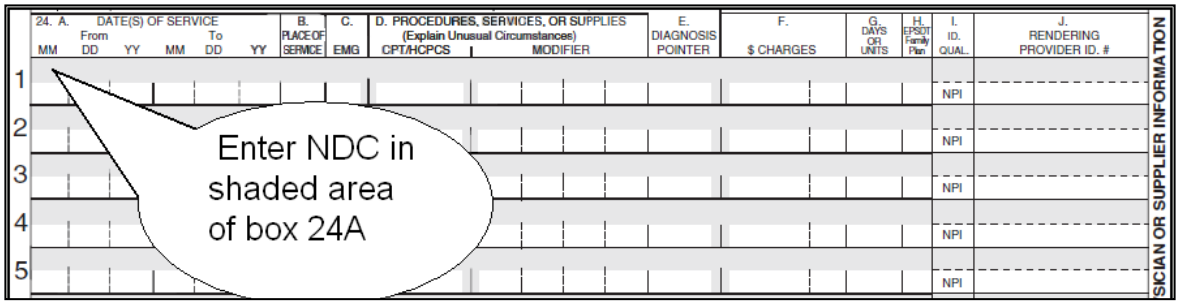
<u>CMS 1500 Claim Form:</u>

- 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.

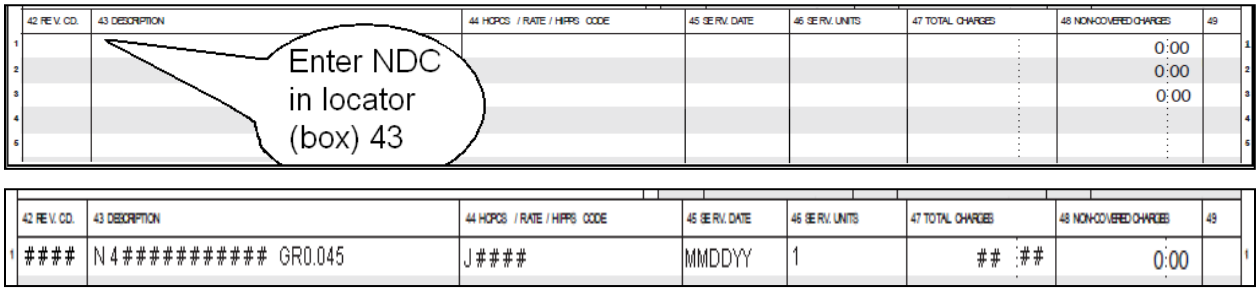
The following table provides elements of a proper NDC entry on a UB04 Claim form.

All elements are required:

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

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

Sample Images of the UB04 Claim Form



Paper Claims Submissions

Digital claim submission, either through the claim submission applications on Availity.com or through EDI, are the preferred method for receiving claims. 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.

Recommended CMS Form 1500 (02-12)

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

UB-04 (CMS-1450)

A sample form is available on the **CMS website: CMS Forms | CMS** along with instructions on how to complete the paper claim form.

Medical Records Submission

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

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

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

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

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

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

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

Medical Records Submission with Initial Claim

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

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

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

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

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

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

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

Digital Request for Additional Information (RFAI)

Providers and Facilities registered for the Medical Attachments application will receive digital notifications when additional documentation is needed to process your Claim. Digital notifications will be posted to your Attachments Dashboard daily when additional documentation

is needed. Most Claims will pend for up to thirty (30) days. After the 30-day pend period, the Claim will deny and you will receive the explanation of payment. An additional digital notification will be posted to your Dashboard for an additional forty five (45) days.

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

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

Types of Claims Documentation Required

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

- History & Physical, Office Visit/Clinical Notes, Treatment Records & Response
- Chemotherapy Regimens, Oncology Drugs, and Records
- Medications List (current and prior)
- Radiology, Diagnostic Imaging, or Diagnostic Testing Reports
- Therapy/Rehabilitation Records
- Laboratory reports, Pathology reports
- Exact description of NOC/NOS code
- Operative/Procedure Report
- Inpatient Admission, History & Physical, Discharge Summary, Physician Progress Notes, Operative/Procedure Report, CT/MRI Report

Anthem May Request Additional Documentation

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

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

- Records documenting prolonged services
- Provider audits
- Pre-pay review program
- Fraud, waste, and abuse

Medical Record Appeals

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

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

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

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

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

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

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

Provider and Facility Identified Overpayments

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

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

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

- **Overpayment Adjustment Form** (see directions below for how to access online)
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Member ID number
- Member's name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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.

How to access the Overpayment Adjustment Request online:

To download the "Overpayment Adjustment Form" directly from **anthem.com**, select **For Providers** from the horizontal menu. On the Provider landing page, choose Forms and Guides. From here, select the Claims & Appeals Category and then select the Overpayment Adjustment Request Form. **Overpayment Adjustment Request Form** Link

Use the correct address noted below to return payment:

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

Medicare Crossover

Claims Handling for Medicare Crossover

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 to 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 that Providers and Facilities submit to the Medicare intermediary will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process may take approximately fourteen (14) days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to thirty (30) additional calendar days for Providers or Facilities to receive payment or instructions from the Blue Plan.

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

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

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

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one (1) other payer, but format limitations permit only one (1) 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/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

Medicare Crossover Claims FAQs

1. **How do Providers 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 a Provider or Facility to send another copy of the Member's Claim, refer the Blue Plan to the local Anthem Plan.

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

   For more information, visit Anthem's Medicare Advantage website at **anthem.com**, or contact the local Anthem plan.

Claim Payment Disputes

Provider and Facility Claim Payment Dispute Process

If a Provider or Facility disagrees with the outcome of a Claim, the Provider or Facility may begin the Anthem Claim Payment Dispute process. The simplest way to define a Claim Payment Dispute is when the Claim is finalized, but a Provider or Facility disagrees with the outcome. Providers and Facilities must complete the Claim Payment Reconsideration and Claim Payment Appeal processes set forth in this Provider Manual before they can initiate the dispute resolution and arbitration process set forth in your Provider or Facility Agreement.

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

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

*Anthem will consider reimbursement of a Claim that has been denied due to failure to meet timely filing if the Provider or Facility can: 1) provide documentation the Claim was submitted

within the timely filing requirements or 2) demonstrate good cause exists. See “Timely Filing for Claims” and “Proof of Timely Filing” in the Claims Filing Tips section of the Manual for more information.

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

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

- **Claim Inquiry:** A question about a Claim or Claim payment is called an inquiry. Claim Inquiries do not result in changes to Claim payments, but the outcome of the Claim Inquiry may result in the initiation of the Claim Payment Dispute. In other words, once the Provider or Facility receives the answer to the Claim Inquiry, the Provider or Facility may opt to begin the Claim Payment Dispute process. Providers and Facilities can Chat with Payer or send a Secure Message through Availity Essentials. If Providers or Facilities are unable to utilize Availity Essentials for the inquiry they can call the number on the back of the Member ID Card and select the *Claims* prompt. For further details on Secure Messaging reference *Availity Essentials* section in this Manual.
- **Claim Correspondence:** Claim Correspondence is when Anthem requires more information to finalize a Claim. Anthem can request this information through the Explanation of Payment (EOP), a digital notification if the provider is registered for Medical Attachments and is using the Digital RFAI process, or through paper mail. The Claim or part of the Claim maybe denied, but it is only because more information is required to process the Claim. Once the information is received, Anthem will use it to finalize the Claim.
- **Clinical/Medical Necessity Appeals**: An appeal regarding a clinical decision denial, such as an authorization or Claim that has been denied as not medically necessary, experimental/investigational. For more information on Clinical/Medical Necessity Appeals, refer to the *Clinical Appeals* section in this Provider Manual.

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

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

Step 1: Claim Payment Reconsideration

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

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

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

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

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

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

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

Step 2: Claim Payment Appeal

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

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

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

Required Documentation for Claims Payment Disputes

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

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

How to Submit a Claim Payment Dispute

There are options to file a Claim Payment Dispute:

- Online through the Availity Essentials Claims Status Application
- Mail all required documentation including the Claim Payment Reconsideration Form to:

  Anthem Claim Payment Dispute
  P.O. BOX 533
  North Haven, CT 06473

- Call the number on the back of the Member ID Card, or found under **Contact Us** on **anthem.com** Provider site.

Clinical Appeals

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

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

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

- Timely filing issues
- Disputes of Prepayment Itemized Bill Review Findings.

Clinical Appeals

Clinical Appeals can be used if Providers or Facilities disagree with clinical decisions. Clinical Appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/investigative. UM program Clinical Appeals involve certification decisions, Claims, or predetermination decisions evaluated on these bases. Clinical Appeals can be made through Availity.com using the Authorizations & Referrals application, verbally, or in writing, or by using for appeals regarding prior authorization clinical adverse decisions.

Anthem Members may designate a representative to exercise their complaint and appeal rights. When a Provider or Facility is acting on behalf of a Member as the designated representative, the complaint or appeal may be directed to Provider Customer Service, using the phone number on the back of the Member ID card. These types of issues are reviewed according to Anthem's Member Complaint and Appeal Procedures, for each applicable state. Provider Customer Service will help Providers and Facilities determine what action must be taken and if a Designation Of An Authorized Representative form is needed. The Designation Of An Authorized Representative form (DOR) can be found online at **anthem.com**. Select **For Providers**, Select **Forms and Guides** (under the Provider Resources column), if needed use the **Change/Select State** link at the top right to select Connecticut. Scroll down and select **Forms and Guides**, then scroll down and select **Claims & Appeals** in the Category drop down and select **Designation of An Authorized Representative Form.**

Guidelines and Timeframes for Submitting Clinical Appeals

- Providers and Facilities have one hundred eighty (180) calendar days to file a clinical appeal from the date they receive notice of Anthem's initial decision.
- All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the appeal request by Anthem.
- For clinical appeals, there are two (2) types of review: expedited and standard.
    - *Expedited Appeal:* Anthem offers an expedited appeal for decisions meeting the expedited criteria. Requests to handle a review as "expedited" are always handled as a Member appeal. Both standard and expedited appeals are reviewed by a person who did not make the initial decision. Unless the Member, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the Member's designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Member Appeal Procedures exclusively.

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

- *Standard Appeal:* A standard appeal is available following the reconsideration, or initially, if it is formally requested.

- UM decisions are communicated in writing to the Provider or Facility and Member. These letters provide details on appeal rights and the address to use when sending additional information.

Requests for appeal of Pre-Service requests will always be handled as a Member appeal. An expedited appeal is available for cases meeting the expedited criteria. Detailed instructions are included in the UM decision letter.

- Appeals should be submitted to Anthem, along with:
  - A copy of the response to the original complaint.
  - Provider or facility name, address, phone number, email and either NPI or TIN
  - The member's name and Anthem ID number
  - Claim, authorization, or reference number and date of service
  - Specific reason(s) for disagreement with decision
  - All supporting statements and documentation (medical records, etc.)
  - A signed DOR (Designation of Representation) is needed if the provider is appealing on behalf of the member. No DOR is required when the provider is appealing on their own behalf.
- Send the appeal request to:

  Anthem Blue Cross and Blue Shield
  Attention: Grievances and Appeals
  P.O. Box 1038
  North Haven, CT 06473-4201

BlueCard® Members

Appeals involving clinical decisions related to Medical Necessity, experimental/investigative and/or Utilization Management (UM) decisions involving Pre-certification/Pre-authorization are the responsibility of the Blue Plan insuring or administering benefits for non-Anthem Members (the Member's Home Plan).

Technically the Member, not the Provider or Facility, is responsible for obtaining the necessary authorization prior to the delivery of non-inpatient admission services. Providers must obtain the necessary authorization prior to the delivery of inpatient admission services. Failure to obtain the necessary authorization may result in non-payment or penalty reduction to the Provider. Anthem understands that many Providers obtain Pre-certification/Pre-authorization or may wish to dispute these types of denials on behalf of, and as a service to, their patients.

- If the appeal relates to Pre-certification/Pre-authorization, the Provider or Facility may have received information directly from the Member's Home Plan regarding appeal rights and processes. Follow the directions provided by the Member's Home Plan.
- If the appeal relates to Claim denial, and the Provider or Facility did not receive this information from the Member's Home Plan and wishes to appeal a Medical Necessity or experimental/investigational Claim denial, the local Anthem Plan is the point of contact.

When a Provider or Facility expresses dissatisfaction and wishes to file an appeal as indicated in the description above, a Claim Payment Dispute should be submitted, along with attached supporting documentation, to the local Anthem Plan. Reference the Claim Payment Dispute section for further details.

- Providers submitting an appeal on behalf of the Member are required to submit a member Designation of Representation (DOR) authorization form. Home Plans may have a specific DOR authorization form.

Member Rights

If the Member's Health Benefit Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA), and the Member has exhausted all mandatory Appeal rights, the Member has the right to bring a civil action in federal court under section 502(a)(1)(B) of ERISA.

The Member can ask Anthem for copies of the specific rule, guideline, protocol or other similar criterion on which a decision was based. A Member can also ask Anthem for reasonable access to and copies of all documents, records, communications and other information and evidence relied upon to make a decision. All this information will be provided upon request and free of charge.

If an adverse determination is based on a Medical Necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances will be provided free of charge upon request.

If a consultant's advice was obtained in connection with a Member's adverse determination, without regard to whether the advice was relied upon in making the benefit determination, the consultant will be identified upon request.

Fully-insured Plan's issued in the State of Connecticut and State of Connecticut Employees

After completion of the Appeals process for an adverse utilization review determination or an adverse non-utilization review determination based on Medical Necessity, a Member, the Provider or the duly authorized representative of the Member or Provider will receive information (including the application) regarding an external appeal process administered by the Insurance Department. The Member must first exhaust all of the utilization review company's internal appeal mechanisms UNLESS it is determined that the time frame for completion of an expedited internal appeal may cause or exacerbate an emergency or life threatening situation. In an emergency or life threatening situation, the Member, or Provider acting on behalf of the Member with the Member's consent, would not need to exhaust all internal appeals in this situation in order to file for an external appeal. The expedited appeal application must be filed with the Insurance Department immediately following receipt of the utilization review company's initial adverse determination or at any level of adverse appeal determination. If the expedited external appeal is not accepted on an expedited basis, and the Member has not previously exhausted all internal appeals, the Member may resume the internal appeal process until all internal appeals are exhausted and then may file for a standard external appeal within one hundred twenty (120) days following receipt of the final denial letter.

The Member, the Provider, or the duly authorized representative of the Member or Provider may, at any time, seek further review of an adverse determination by writing to the Insurance

Commissioner at State of Connecticut, Insurance Department, Consumer Affairs, P.O. Box 816, Hartford, CT 06142, or by calling (860) 297-3910.

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

Anthem is committed to sharing reimbursement requirements and policies on how Anthem will reimburse Providers and Facilities for certain services. Reimbursement policies are all published on anthem.com; check there first for the most up-to-date policy information. Go to **anthem.com**, select **For Providers**, then select **Policies, Guidelines and Manuals**. Select **Connecticut**, and then select **Reimbursement Policies**, or use this link: **Reimbursement Policies**

Anthem reserves the right to review and revise policies when necessary. When significant changes are made to reimbursement policies, a notification will be published in *Provider News*, Anthem's monthly newsletter, alerting Providers and Facilities to the updates and directing access to the reimbursement policies link to review the changes.

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/outpatient encounter. 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	Discharge
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, which could otherwise be provided in an office setting. Anthem will not separately reimburse for Courtesy Room charges.

Eligibility and Payment

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

Emergency Room Same Day Visits

Occasionally, a Member may require two (2) visits to the emergency room on the same day at the same Facility. Even though both Claims would have different patient control numbers, one Claim will automatically deny as duplicate to the other Claim. To help Anthem identify Claims that are not duplicates, include the admit hour (form locator 13) and the discharge hour (form locator 16).

Emergency Room Services with Next Day Admission

Emergency Room services resulting in next day inpatient admissions require the Facilities to bill separate Claims for Emergency Room and Inpatient charges.

Emergency Room Supplies and Services Charges

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

Evaluation and Management (E&M) Services

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

- Deny the Claim and request resubmission of the Claim with the appropriate E&M level;
- Pend the Claim and request that the Facility or Provider submit documentation supporting the E&M level billed; and/or
- Adjust reimbursement to reflect the lower E&M level supported by the Claim

Providers who believe their medical record documentation supports reimbursement for the originally submitted level for the E/M service will be able to follow the Claims Payment Disputes process as outlined in the Provider Manual. Policies are found at the Reimbursement Policies page at anthem.com.

Faculty Personnel Services

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate or procedure charge. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions (including IV or PICC line insertion at bedside), 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. Examples of general industry standards include, but are not limited to, HCPCS, ICD10/CM, health service codes (also known as Revenue Codes) per the UB-04 Claim billing manual or subsequent forms CPT codes.

General Rules Relating to Facility Payment Methodologies

Services are reimbursed using a Case Rate, Per Diem, Per Visit, Fee Schedule Rate, Percentage Rate and Other Outpatient Rate payment methodology based on the Facility

Agreement. These allowances include, but is not limited to, reimbursement for professional services, blood, blood products, processing, storage and administration, monitoring services performed in connection with devices inserted or equipment used in part of an Inpatient or Outpatient Service, Anthem New York Provider Manual – Effective November 1, 2023, 89 comprehensive health planning, courtesy room, daily supply or one time charge fees/items, Facility personnel charges, instrument trays, implants, equipment and supplies, drugs/ medications, nursing procedures, all ancillary services (including but not limited to laboratory and x-ray), DME, room and board charges, personal care items, portable charges, pre-operative care and holding room charges, preparation charges, ambulance charges, recovery room, special procedure room charge, stand-by charges and video equipment used in operating room.

Incidental Procedures

Procedures that are performed concurrently with, and are clinically an integral part of, the primary procedure will not be reimbursed separately. The fees for any incidental procedure will be denied and Anthem will reimburse the allowed amount for the primary procedure only. Certain services and supplies that are considered part of overall care are not separately reimbursed. These may include procedures identified as Status “B” by CMS. Anthem considers the use of surgical trays and supplies to be incidental (part of the technique) to surgical procedures and therefore not separately reimbursed. Anthem’s fees for surgical procedures include these items and techniques.

Instrument Trays

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

IV Sedation and Local Anesthesia

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

Lab Charges

The reimbursement of charges for specimen collection 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 Member

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

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family Member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

Neuromonitoring

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 Treatments

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, 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 reimbursement will reflect the cost of:

- The use of the operating room

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

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 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 his/her 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 bedside 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. Reimbursement is included in the reimbursement for the room, procedure, or observation charges.

Rounding of Allowances

Covered Services priced at a Case Rate, Per Diem Rate or Per Visit rate, including those being modified for the Q-HIP adjustment, if applicable, will be rounded to the nearest whole dollar. In addition, the base rate used to calculate the DRG Case Rate shall be rounded to the whole penny to the extent applicable.

Covered Services priced at a Fee Schedule Rate, including those being modified for the Q-HIP adjustment, will be calculated using whole percentages. The resulting Fee Schedule Rate allowance will be rounded to two (2) decimal places.

Covered Services priced at a Percentage Rate will be rounded to two (2) decimal places. By way of example but not limited to, if the Anthem Rate requires a price adjustment due to an audit finding, the resulting Percentage Rate will be modified and rounded to two (2) decimal places.

If applicable, when Q-HIP adjustment and inflationary Rate Increases coincide on the same effective date, the Q-HIP adjustment and the rate increase will first be added together and the result will be applied to the Anthem Rate using the rounding rules previously detailed above. For illustrative purposes only, if the rate increase was 3.5%, the Q-HIP adjustment was 0.85%, the Anthem Rate was $755 Per Diem, and the inflationary Anthem Rate with Q-HIP adjustment would equal $.

(1.035 +.0085) x 755 = 1.0435 x 755 = $787.8425 which would be rounded to $788.

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.

Special Procedure Room Charges

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, then OR time will not be reimbursed to cover OR personnel/staff being present in the room. Refer to Operating Room Time and Procedure Charges for OR definition. Example: procedures performed in the ICU, ER, etc.

Stand-by Charges

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

Stat Charges

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

Submission of Claim/Encounter Data

Providers and Facilities will submit Claims and Encounter Data to Anthem in a format 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 Facilty 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.

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.

Transfers

Transfer to and from other Facilities requires prior authorization by Anthem's Medical Management Department. Anthem does not approve transfers between acute Facilities unless the transfer is considered to be Medically Necessary. When a transfer is approved for an inpatient Covered Service for which Facility is reimbursed on a "Per Case" basis or actual charges due to "Lesser of" reimbursement methodology (i.e. when Facility's actual charge is less than the "Per Case" negotiated amount), reimbursement to Facility will be apportioned so

as to avoid duplicate payment based on the percentage of the admission that the patient was inpatient at Facility. The per diem rate is calculated by dividing the DRG case rate by the average length of stay (GMLOS for MS DRG). For transfers for admissions for which Facility is reimbursed under a "Per Diem" payment methodology, the inpatient stay at each applicable Facility shall be treated as an "Admission" as defined above and Facility shall be reimbursed under the "Admission" rules described above.

Undocumented or Unsupported Charges

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

Video or Digital Equipment Used in Procedures

Charges for video or digital equipment used for visual enhancement during a procedure are included in the reimbursement for the procedure and are not separately reimbursable. Examples include but 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 Excluded Items**
0990 – 0999	Personal Care Items • Courtesy/Hospitality Room • Patient Convenience Items (0990) • Cafeteria, Guest Tray (0991) • Private Linen Service (0992) • Telephone, Telegraph (0993) • TV, Radio (0994) • Non-patient Room Rentals (0995) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
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 • Suction Canisters/Tubing/Tips/Catheters/Liners • Enteral/Parenteral Feeding Supplies (tubing/bags/sets, etc.)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• 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)

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
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 • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies

Facility Responsibility	
Typically Billed Under This/These Revenue Codes, but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
	• 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)

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

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	**Description of Excluded Items**
0110 – 0119	Private Room*
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 benefits

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 year or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines online. To access the guidelines, go to anthem.com. Select **For Providers** and **Connecticut** then select **Policies, Guidelines and Manuals** from the horizontal menu under Provider Resources. Scroll to Clinical Practice Guidelines and select "**Download the Index**".

Clinical Practice Guidelines Link.

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**. Select **For Providers** and **Connecticut** 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 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 preventive health guidelines.

Medical Policies and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, “Medical Policy) for the health plan. The principal component of the process is the review for development of Medical Necessity and/or investigational and not medically necessary position statements or clinical indications that are objective and based on medical evidence for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments may include, but are not limited to devices, biologics, specialty pharmaceuticals, gene therapies, and professional health services.

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

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

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

Medical Policy and Clinical UM Guidelines Distinction

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

Accessing Medical Policies and Clinical UM Guidelines

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

To locate Medical Policy online, go to **anthem.com**. At the top of the screen, select **For Providers,** and then under the **Provider Resources** heading, select the **Policies, Guidelines & Manuals**, then select **Connecticut.** Scroll down to select "**View Medical Policies & Clinical UM Guidelines**". Search for policies and guidelines using keyword or code, or select "Full List page" to view. Page link is included below:

Medical Policies and Clinical Guidelines

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

Medical Policy and Prior Authorization for Blue Plans

Clinical UM Guidelines

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

To view the list of specific clinical UM guidelines adopted by Connecticut, go to anthem.com, select **For Providers** and choose **Policies, Guidelines and Manuals** under the Provider Resources menu. Select **Connecticut,** if needed. Scroll to Clinical UM Guidelines Adopted by Anthem Blue Cross and Blue Shield in Connecticut.

anthem.com/provider/policies/clinical-guidelines

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**. Select **For Providers,** under **Provider Resources** select **Policies, Guidelines & Manuals**, then select **Connecticut** , select **View Medical Policies & Clinical UM Guidelines,** scroll to **Other Criteria** and select the desired criteria.

Utilization Management

Utilization Management Program

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

The Utilization Management (UM) program goal is that 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. Provider or Facility shall comply with all requests for medical information required to complete UM reviews. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined within this UM 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 Provider(s), Facility and the Member documenting the UM determination.
6. **Precertification (includes Pre-authorization/Pre-service/Prospective):**List of services that require Review by UM prior to service delivery. For UM team to perform this Review, the Provider submits the pertinent information as soon as possible to UM prior to service delivery.

Review Types

- **Prospective Review:** Utilization review that is conducted on a health care service (or supply) that requires Pre-certification prior to its delivery to the Member.

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

Program Overview

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

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

Provider or Facility 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, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

UM will provide electronic or written Notification for determinations to the Member, provider and/or facility, as applicable.

UM Review Timeframes follow Federal, State and accreditation requirements as applicable review.

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

- The information submitted with the Claim, or on the medical record, differs from that given for the pre-Claim UM review.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

Inpatient admissions require UM review. UM 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 including site of service and level of care.

Non-inpatient services may require Pre-Certification Review.

The list of Pre-Certification Requirements can be accessed online. Go to **anthem.com** and select **For Providers**. Under the **Claims** heading, select **Prior Authorization**. Select **Connecticut**. Select the appropriate link depending on the type of Member Plan.

The Pre-Certification requirements may also be confirmed by contacting the appropriate phone number on the back of the Member's ID card.

Provider or Facility shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.

Pre-service Review & Continued Stay Review

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

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

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 "Member Medical Records Submission (Solicited AND Unsolicited)" 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 48 hours of an emergency admission even if records are reviewed retrospectively.

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 (EMR) Review

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.

Failure to Comply With Utilization Management Program Processes

Provider and Facility acknowledge that Anthem may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility’s failure to provide notice of admission or obtain Pre-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/Pre-authorization as specified by Anthem that are not submitted for review and a decision rendered before the service occurs payment will be subject to a 100% penalty unless extenuating circumstances exist as further described below. Providers and Facilities can only dispute the 100% penalty in order to present evidence of extenuating circumstances.
- Payment for emergency inpatient admissions will be subject to a 100% penalty if the notification is not provided within forty-eight (48) hours of admission. Providers and Facilities can only dispute the 100% penalty in order to present evidence of extenuating circumstances by requesting a Claim Payment Reconsideration as further described in the Claims Payment Disputes section of this manual. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

Extenuating Circumstances Approval List

- Insurance information was not available from the Member at the time of admission or incorrect information was received from the Member, due to illness, mental status, or language differences at the time of services. Including primary payer issues (e.g., Medicare, AKA admissions or VIP Member admitted under a false name, etc.).
- Anthem Health system problems prevented authorization from being obtained or Anthem Health provides erroneous information, (e.g., misinformation about authorization requirements or Member eligibility).
- Admission or services received are court ordered.
- The need for another covered service was revealed and performed at the time the original authorized service was performed, the newly revealed covered service would not receive a late call penalty
- The Member presented with 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 Facility or Provider 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 requests offers a streamlined and efficient experience for Providers and Facilities requesting inpatient and outpatient medical services for Members covered by Anthem plans. Providers and Facilities can also use the Availity Essentials Authorization application to check authorization status, regardless of how the authorization was submitted. To

submit digital prior authorizations log onto Availity.com 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

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

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

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

MCG™ (formerly known as Milliman Care Guidelines®)

The company licenses and utilizes MCG™ (formerly known as Milliman Care Guidelines®) and may also license and/or utilize the guidelines of other entities.

Responsibility for Prior Authorization

For HMO type health plans: Under Anthem HMO plans and products:

- It is the participating physician's or Provider's responsibility to contact Anthem's Utilization Management Department at (800) 238-2227, or such other number indicated below for specific services, to obtain prior authorization.
- The request must come from the Provider or Facility rendering the service, not the referring physician, except where described below for specific services.
- If prior authorization is not obtained, the Claim payment may be reduced or denied by Anthem and the Member must be held harmless.

For PPO type health plans: Under Anthem PPO plans and products:

- **Services provided by a network Provider:** The Provider is responsible for prior authorization.
- **Services provided by a BlueCard® or non-participating Provider:** The Member is responsible for prior authorization. The Member is financially responsible for services and/or settings that are not covered under the certificate based on an adverse determination of medical necessity or experimental or investigational services.

Balance Billing for Services Considered Not Medically Necessary

Be aware that if services are rendered that are not Medically Necessary or are considered experimental/investigational to an Anthem Member, the Member may only be billed for such services if a signed/written, dated, waiver from the Member has been obtained prior to the services being performed.

The waiver should specify the following:

- the specific Health Services and date they are to be performed,
- confirmation that the services are likely to be deemed not Medically Necessary or experimental/investigational,
- the approximate cost of the Health Service, and
- the date of the Member's signature.

Emergency Admissions Authorization

Authorization is required within forty-eight (48) hours or two (2) business days when a Member of Anthem HMO plans or PPO programs with Managed Benefits is admitted on an emergent basis. See below for plan specific guidelines.

BlueCare Health Plan and New England Health Plans

- In an emergency situation, Members are directed to go immediately to the nearest Emergency Room and, if possible, to contact their PCP before going to the ER.

- Emergency admissions must be reported to the UM Department within forty-eight (48) hours or two (2) business days.
- Members are generally responsible for an Emergency Room co-payment for each visit that does not result in the patient being admitted as an inpatient directly from the Emergency Room.

Emergency Treatment from a Non-Participating Provider

- If a Member requires Emergency Services from a non-participating Provider, no prior authorization from Anthem or the PCP is required.
- The Member must contact their PCP to arrange any medically necessary follow up care as soon as possible.
- If the Member is admitted: The Member or admitting physician must report all inpatient admissions to the UM Department within forty-eight (48) hours or two (2) business days of admission.

Century Preferred, Century Preferred Comp and State Preferred

- Hospital admissions resulting from covered Emergency Services are subject to the Managed Benefits guidelines.
- Coverage is provided for the initial Emergency Room visit for emergency medical care, emergency accident care, serious and sudden illness care and accidental ingestion or consumption of a controlled drug, if the services commence within seventy-two (72) hours of the accident or injury. Compensation will only be provided for Covered Services for Medically Necessary care.
- Century Preferred: there is a co-payment for the use of the Emergency Room. The co-payment is waived if the Member's visit to the emergency room results in immediate admission to the hospital.
- State Preferred: There is a copayment of $35 for the use of the Emergency Room for State Preferred insured active employees and retirees whose retirement became effective October 1, 2011, or later. For retirees with retirement dates prior to October 1, 2011, there is no copayment.

Urgent Care

BlueCare Health Plan, State BlueCare, Century Preferred (including Century Preferred comp) State Preferred, BlueCard POS, FEP Standard Option and Basic Option Members have access to a comprehensive, hospital-based urgent care Network for urgent care twenty-four (24) hours a day, seven (7) days a week, when the Member's physician may not be available.

Urgent care Facilities provide:

- **Triage service** – Medical professionals determine if the Member requires Emergency Services or urgent care. Access to the emergency room is available when medically necessary.
- **Extended hours of service** – available to Members at any time.

- **Shorter wait times** – 90% of Members must be treated within sixty (60) minutes based on Anthem defined standards of care.
- **Access to hospital Facilities** – availability to hospital equipment, technologies, and other onsite ancillary services including x-ray, laboratory and pharmacy.
- **Quality Monitoring** – via Provider auditing and satisfaction surveys.

Urgent care criteria

1. No referral is required for urgent care. However, Members are encouraged to contact their PCP in an urgent situation. Members may self-refer to a participating urgent care Facility at any time.
2. The urgent care Facility must be participating to be eligible for in Network coverage.
3. If the Member is admitted to the hospital as a result of the visit to an urgent care Facility, the UM department must be notified within forty-eight (48) hours or two (2) business days of the admission at **1-800-238-2227**
4. Members are responsible for applicable urgent care visit co-payments. Members are also responsible for a co-payment for each covered emergency room visit that does not result in an inpatient admission.
5. Services rendered must meet urgent care criteria in order to be eligible for coverage. Urgent care refers to services that can be provided for an injury or illness that isn't an emergency, but does not require immediate attention. Routine primary care (physical exams), preventative care (routine immunizations), and occupational health care (PT exams for employment) will be ineligible for coverage as urgent care.
6. Urgent care Facilities may not be used as a "back-up" for the PCP. PCPs who act as care coordinators may not "sign out" to a walk in center for covering purposes.

Behavioral Health/Substance Abuse Services

Anthem's behavioral health and substance abuse benefits in Connecticut are administered by professionals who are specially trained to handle referrals and coordinate care. Call (800) 934-0331 for Inpatient behavioral health and substance abuse admissions. Prior authorization is also required for the following outpatient and residential services:

- Residential Care
- Partial hospital program (PHP)
- Intensive outpatient programs (IOP)
- Transcranial Magnetic Stimulation (TMS)
- Behavioral Health In-Home programs
- ABA – Applied Behavioral Analysis is not a standard benefit. If ABA is covered for a Member, prior authorization is recommended. Prior authorization for psychological testing and outpatient services varies by products and plan; contact the customer service number for requirements or when verifying eligibility. Professionals are available 24 hours a day, seven days a week.

For benefits to be paid, the Member must be eligible on the date of service and the service must be a covered benefit under the policy.

Carelon Medical Benefits Management

Carelon Medical Benefits Management provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million Members across 50 states, D.C. and U.S. territories, Carelon Medical Benefits Management promotes optimal care through use of evidence-based clinical guidelines and real-time decision support for both Providers and their patients. 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, resources, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to the provider portal.

Submit Precertification to Carelon Medical Benefits Management

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

- Access the provider portal directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Call the Carelon Medical Benefits Management Contact Center toll-free number: 866-714-1107, Monday through Friday, 8:00 a.m. to 5:00 p.m. ET

OptiNet Registration

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

To access the OptiNet Registration:

- Access the 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 as the Provider or Facility proceeds through the registration. Once the registration has been submitted,

a score card will be produced. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact Web Support at **800-252-2021**. For any other questions, contact an Anthem Provider Service Center.

Quality Improvement Program

Quality Improvement (QI) Program Overview

The Quality Improvement Program Description (QIPD) (QIPD) defines the quality infrastructure that supports Anthem's QI strategies. The QIPD establishes QI Program governance, scope, goals, objectives, structure, and responsibilities encompassing the quality of medical and behavioral healthcare and services accessible to Members.

Healthcare is local and Anthem has a strong local presence required to understand and support Member needs and provide access to covered care. Anthem is well positioned to deliver what Members want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Local presence and broad expertise create opportunities for collaborative programs that support Providers and Facilities achieving clinical quality and excellence. Participating Providers and Facilities are expected to cooperate with quality activities. Commitment to health improvement and care management provides added value to Members and Providers – helping improve both health and healthcare costs. Anthem takes a leadership role to improve the health of communities and is helping to address key healthcare issues

Guided by its whole health strategy, Anthem uses digital-first solutions to support provision of exceptional experiences, affordability, quality and broadened access to consumers and communities. Our digital solutions are the driving force behind shaping our strategy. Digital access to care is one of the enablers that allows us to create value, respond to societal shifts and meet market and consumer needs. We have a continued focus on integrating data, analytics, insights and digital technologies into every aspect of the business.

The annual QI Work Plan is a dynamic process and reflects ongoing progress made on quality activities. The QI Work Plan includes measurable objectives for the year to determine how well the health plan is performing, including activities addressing quality of clinical care, safety of clinical care, quality of service and Members' experience.

The QI Program Evaluation assesses outcomes of Anthem's medical and behavioral health care programs and activities toward established goals and objectives.

Goals and Objectives

The goals and objectives support Anthem's vision and values are responsive to the changing needs of Members, Providers and Facilities and the healthcare community and focus on being a valued health partner across the healthcare continuum. Anthem implements evidence-based interventions from both external and internal sources to help build and deliver the best value to customers.

- Develop and maintain a well-integrated system to identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.
- Evaluate performance in order to take action and respond to the needs of internal/external customers, including compliance with policies, procedures, contractual and regulatory and accreditation requirements.
- Build a safer and more equitable health system through the creation of a safety culture that improves the delivery of healthcare, health outcomes and alignment with national patient safety efforts.
- Identify and promote educational opportunities for Members, medical and behavioral health Providers.
- Advance health equity locally and nationally to improve lives and communities.
- Address the cultural and linguistic needs of eligible Members to promote improved health and healthcare outcomes for diverse Members.
- Help maximize health status, improve health outcomes and reduce healthcare costs of Members through effective Case Management (CM), which includes Behavioral Health (BH) and Disease Management (DM) programs addressing complex care needs and Population Health Management (PHM) which includes CM, BH and DM.

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

Quality and Safety of Clinical Care

- **Community Health:** Anthem has committed resources and worked with key entities to co-create community-based health initiatives to address public health concerns and societal problems including behavioral health/substance use, cancer, vaccinations, maternal and child health and health equity.
- **Health and Wellness**: MyHealth Advantage is a proactive program that translates a Member's health information into personal guidance to help improve the safety, quality and coordination of their healthcare. This program provides personalized, actionable messaging to Members and their Providers on ways they can improve their health; optimize healthcare spending; avoid critical health issues.
- **MyHealth Coach** program offers end-to-end (enroll, engage and manage) professional one-on-one guidance from an experienced health coach. Each health coach provides education, resources, tools and support to help Members make wise informed decisions about their healthcare. Members are helped to navigate the healthcare system, comply with prescribed treatment plans and use health benefits more appropriately. The health coach serves as a central point of contact for Members who have questions or concerns about a healthcare topic or condition.

Patient Safety for Members

Anthem's mission is improving lives and communities, and the quality framework supports this with the promotion of continuous improvement in patient safety. The patient safety goals are to build a safer, more equitable health system and decrease the occurrence of patient safety events by creating a safety culture that improves the delivery of healthcare, health outcomes

and alignment with national patient safety efforts. This will be accomplished through the promotion of safe clinical practices in aspects of clinical care and service; to engage Members and medical and behavioral health Providers concerning patient safety in aspects of patient interaction; and to identify opportunities for system and process improvements that promote patient safety within individual practices and across the healthcare continuum. Areas for monitoring are selected by analyzing patient safety data for Members inherent to quality of medical and behavioral healthcare delivery and service. Areas of focus include Population Health Management programs that target keeping members healthy, managing members with emerging risk, patient safety or outcomes across setting and managing multiple chronic illnesses.

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

Member Rights and Responsibilities

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

Continuity and Coordination of Care

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

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

Continuity of Care/Transition of Care Program

This program is for Members when their Provider 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 Consolidations Appropriations Act (CAA), effective January 1, 2022, there are federal continuity of care obligations resulting from (i) the termination of Providers or Facilities from Anthem's network and (ii) the termination of a group health plan from Anthem that results in a loss of benefits provided under such group health plan with respect to Provider or Facility.

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

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

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

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

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

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

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

leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Performance Data

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

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

Overview of HEDIS®

HEDIS *(Healthcare Effectiveness Data and Information Set)* is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Data is collected in four ways: Administratively, Hybrid, Survey or via Electronic Clinical Data Systems. Currently, HEDIS includes 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**, select **For Providers**, select **Forms and Guides** (under the Provider Resources column), if the state is not already populated in the State field, **pick the state** using the **Change State** link at the top right. Scroll down and select Forms and Guides, then scroll down and select **HEDIS** in the Category drop down.

*Subject to change

HEDIS Information link

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).

Culturally and 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 Anthem's programs are developed in partnership with the Blue Cross and Blue Shield Association (BCBSA) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME Providers as Blue Distinction Centers for Specialty Care. Using objective information and input from the medical community, the BCBSA has designated hospitals, ambulatory surgery centers (ASCs), physicians, and/or clinics as Blue Distinction Centers that are proven to outperform their peers in the areas of quality, safety and, in the case of Blue Distinction Centers+, cost efficiency.

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

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

Transplant

- Blue Distinction Centers for Transplant™ (BDCT) launched in 2006.
- Nearly 104,000 people in the United States were waiting for a lifesaving organ transplant from one of the nation's more than 250 transplant centers in the United States as of

December, 2022. In the United States, there were more than 42,800 organ transplants in 2022. In 2022, annual records were set for the total number of kidney, liver, heart and lung transplants.

- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research (CIBMTR), the Scientific Registry of Transplant Recipients (SRTR), and the Foundation for the Accreditation of Cellular Therapy (FACT), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers' standards for quality while also demonstrating better cost-efficiency relative to their peers.
- The Anthem CME Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant programs. When BDCT and Anthem CME are combined, Members have access to over 800 transplant specific programs for adult and pediatric heart, lung, liver, kidney, and bone marrow/stem cell transplant, and adult combined heart/lung, combined liver kidney, pancreas, and combined kidney/pancreas transplant.

Cardiac Care

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

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008

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

Cancer Care

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

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009.
- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available for Providers to work with Members, to guide them toward the most appropriate recommendation for their situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- In 2019, Blue Distinction Specialty Care Program for Spine Surgery expanded to include alternate sites of care, such as ambulatory surgery centers (ASCs) and hospitals without an onsite ICU.

- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, cervical and lumbar fusion, cervical laminectomy, lumbar laminectomy/discectomyand decompression procedures.
- To date, Anthem has designated hospitals in the majority of states across the U.S.

Knee and Hip Replacement

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

Maternity Care

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

Substance Use Treatment and Recovery

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

Ventricular Assist Devices

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

Cellular Immunotherapy

- 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 provide 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 for treatment in Pediatric and Adult Patients
    3. Tecartus™ (Brexucabtagene Autoleucel) for treatment in Adult Patients
    4. Abecma® (idecabtagene vicleucel) for treatment in Adult Patients
    5. Breyanzi® (idecabtagene maraleucel) for treatment in Adult Patients
    6. Carvykti® (ciltacabtagene autoleucel) for treatment in Adult Patients
    7. Omisirge (omidubicel) for treatment in Pediatric and Adult Patients
- These procedures can be performed in the Inpatient (IP) or Outpatient (OP) setting and Care and follow-up continues over the first year.
- These Members are managed by the transplant Case Managers and Anthem Medical Policy requires the procedure be performed at a Certified CAR-T center.
- Anthem has a Centers of Medical Excellence Network that continues to expand. These programs are reviewed by our Bone Marrow National Transplant Quality Review Committee. Currently we have eight (8) contracted CAR-T CME Providers. Until a Provider or Facility is contracted, each referral will require a Letter of Agreement.
- The Blue Cross Blue Shield Association also has a designation, but not a contract requirement for CAR-T Providers in 2020. Providers must be certified by a product manufacturer certification program to deliver CAR-T therapy.

Gene Therapy

- The U.S. Food & Drug Administration (FDA) continues to approve new gene therapy products which provide new treatments for various conditions. This treatment involves Gene therapy that introduces or is related to the introduction of genetic material into a person intended to replace or correct faulty or missing genetic material

Audit and Review

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

Anthem Audit and Review Policy

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

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

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

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

Definition

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

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

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

Documents Reviewed During an Audit or Review

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

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

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

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

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

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

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

Policy

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

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

- A Provider's or Facility's physical or electronic address may be confirmed prior to sending an initial request for supporting documentation.
- When a response is not received within thirty (30) days of the date of the initial request, a second request will be sent.
- When a response is not received within fifteen (15) days of date of the second request, a final request will be sent.
- When a response is not received within fifteen (15) days of the date of the final request sixty (60) days total:
  - Anthem or its designee will initiate a Claim denial for Claims identified for pre-payment review or post payment audit when a Provider or Facility fails to submit the required documentation. The Member shall be held harmless for such payment denials.

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

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

Procedure

- Review of Documents: Anthem or its designee will request in writing any supporting documentation required for audit or review. The Provider or Facility will supply the requested documentation within the time frame outlined above.
- Desk or Off-site Audits: Anthem or its designee may conduct Audits from its offices and/or offsite locations. Facility or Provider will comply with timeline and specific requested documentation listed in Anthem's request for additional documentation.
- Completion of Desk or Off-site Audit: Upon completion of the Audit where an overpayment is identified, Anthem will generate a Notice of Overpayment. The Notice of Overpayment will identify the Claim overpayment and include an explanation remark for the overpayment. If the Provider or Facility agrees with the Notice of Overpayment, then the Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the form of a refund.

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

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

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

  All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.
- Completion of Audit (On-site Audit only): Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit.

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

  If the Provider or Facility agrees with the Audit findings and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging Agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.
- No Appeal (On-site audit only): If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the thirty (30) calendar day timeframe, the initial determination will stand and Anthem or its

designee will process adjustments to recover the amount identified in the final Audit Report.

- Scheduling of Audit (Hospital Bill Audits Only): After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
- Rescheduling of Audit: Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.
- Under-billed and Late-billed Claims: During an 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.

Chargemaster Audit Process and Procedure

1. Anthem conducts audits and intra year reviews to confirm that charges for Covered Services are in compliance with Facility's Agreement. Anthem may request documentation that typically might not be included in data received via Claims. This policy documents Anthem's guidelines for such audits including additional documentation requests, the Facility's obligation to comply with such requests, and the audit process flow.

   Anthem shall provide Facility with notice of intent to Audit which shall be accompanied by a request for data. Facility shall respond within thirty (30) days of such request in an electronic format acceptable to Anthem which shall include:

   (1) its full Chargemaster that is in effect as of the date(s) included in Anthem's request and its effective date,

   (2) Facility's Chargemaster that was in effect immediately prior and its effective date, and

   (3) the projected financial impact (percentage increase) of the change to Anthem's commercial business between the two Chargemaster submissions for Covered Services that are reimbursed using a Percentage Rate.

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

   Chargemaster submissions shall include, but may not be limited to, the following fields:

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

In addition, Facility shall provide utilization for Anthem commercial Covered Individuals for Inpatient Services and Outpatient Services in an electronic format acceptable to Anthem for all Anthem commercial Claims reimbursed or partially reimbursed using a Percentage Rate for the time periods listed in the above request.

Utilization submissions shall include, but not be limited to, the following fields:

- Facility Identifier
- Patient account number
- Date of service
- Charge code description
- Department or cost center
- Billed Charges
- Billed units

2. The following definitions shall apply to this Chargemaster section only:
   a) Baseline Period is the twelve (12) months prior to the Chargemaster Audit Period.
   b) Actual Charges is the total dollar amount charged for Chargemaster Audit Period for Claims for Anthem commercial Covered Individuals reimbursed at Percentage Rate extracted from Anthem's claim system.
   c) The charge code detail will be utilized for analysis if submitted by Facility. In absence of that submission, the average per unit charge by CPT/HCPCS for Outpatient Services and by room and bed revenue code for Inpatient Services will be used as a proxy for the analysis.
   d) Repriced Charges is the total dollar amount (for all Charge CPT codes) of the Average per unit charge by Charge CPT code multiplied by the Chargemaster Audit Period utilization. This would have been the total charge amount if no Chargemaster change was implemented.
   e) Adjusted Charges is the Repriced Charges increased by the greater of the MAPI or what was provided in the Facility notice of Chargemaster impact.
   f) Charge Variance is the difference in dollars between the Actual Charges for the Chargemaster Audit Period and the Adjusted Charges.
   g) Actual Chargemaster Impact Percentage is calculated as the difference between the Repriced Charges and the Actual Charges.

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

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

   Anthem shall calculate the Overpayment Amount by multiplying the Charge Variance by a percentage which shall be calculated utilizing the Anthem Rate for all Covered Services reimbursed at Percentage Rate weighted by the utilization of those services.

   Formula:

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

   Example:

   - Actual Charges = $100

   - Repriced Charges = $90 (Chargemaster Audit Period utilization x average per unit Charge by CPT code for baseline period)

   - MAPI = 2%

   - Facility Notice of Chargemaster impact = 3%

   - Average Percentage of Charge = 50%

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

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

   If Claims have been overpaid as a result of the MAPI has been exceeded in accordance with the audit procedure above (as a result of the adjusted Anthem Rate not being in effect as of the effective date of the Chargemaster change), Anthem shall be entitled to full reimbursement of such overpayments. To the extent that the parties are unable to come to an agreement for a timely recovery of the overpayment, Anthem shall be entitled to implement a payment recovery via adjustment of Anthem Rates.

4. Facility shall have fourteen (14) days to accept or dispute the Audit results. If Facility does not respond within the fourteen (14) day period, then Facility shall be deemed to have accepted the results.

   Should Facility dispute the results of the Audit within fourteen (14) days of the results notification and identify the basis for such dispute and its supporting data and methodology, Anthem shall review the additional data and any feedback. Any dispute to the adjusted Anthem Rates that is not accompanied by data to substantiate such dispute shall not be considered.

   If the additional data or feedback from Facility results in a revision of the audit results, Anthem shall provide Facility with revised Audit results which Facility shall have fourteen (14) days to accept or dispute the results.

5. The following circumstances set forth below shall permit Anthem to adjust the Anthem Rates to neutralize the excess to MAPI reported in any written Attestation or calculated as a result of a completed audit not accounted for in any previous adjustment from the date the Chargemaster change went into effect until the date that the adjusted Anthem Rates shall go into effect without requiring an amendment to the Agreement. Adjustments made to the Anthem Rates are intended to ensure that the amount payable for Covered Services reimbursed at a Percentage Rate do not exceed the amount that would have been reimbursed had the Facility not implemented changes to its Chargemaster in excess of the MAPI. Anthem shall provide Facility with thirty (30) days notice of such changes and applicable impacted claims shall be reprocessed unless otherwise agreed to by the parties in writing. Standard rounding procedures shall be used calculating to the nearest whole dollar or two decimal places for percentages. Additionally, any applicable thresholds tied to charge based calculations shall be increased by the same percentage as the Inpatient Charges and Outpatient Charges.

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

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

    iii) If a completed and undisputed audit indicates that Attestation and/or MAPI has been exceeded.

    iv) If a completed audit indicates Attestation and/or MAPI has been exceeded and Facility's dispute of such audit is untimely or incomplete.

    v) If, despite good faith efforts, either party determines that they are unable to reach a resolution to an audit discrepancy.

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 or its designee within forty-five (45) calendar days of the date of the Notice of Overpayment unless applicable law expressly indicates otherwise. The Appeal should address the findings from the Notice of

Overpayment that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the forty-five (45) calendar days unless expressly prohibited by contractual obligations or applicable law.

2. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Notice of Overpayment. Anthem's or its designee's response shall be sent via email, mail or portal to the Provider or Facility within forty-five (45) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation.
3. The Provider or Facility shall have thirty (30) calendar days from the date of Anthem's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the thirty (30) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
4. Upon receipt of a timely Provider or Facility appeal response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. Anthem's or its designee's final Appeal Response shall be sent via email, mail or portal to the Provider or Facility within thirty (30) 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 thirty (30) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the thirty (30) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response.

Fraud, Waste and Abuse Detection

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

- **Fraud**: Any type of intentional deception or misrepresentation made with the knowledge that the deception could result in some unauthorized benefit to the person, or any other

person committing it. This includes any act that constitutes fraud under applicable Federal or State law.

- **Waste:** Includes overusing services, or other practices that, directly or indirectly, result in excessive costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.
- **Abuse:** Behaviors that are inconsistent with sound financial, business and medical practices and result in unnecessary costs and payments for services that are not medically necessary or fail to meet professionally recognized standards for health care. This includes any member actions that result in unnecessary costs.

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

Reporting Fraud, Waste and Abuse

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

Report concerns:

- Visit anthem.com, scroll to the bottom footer and click on “Healthcare Fraud Prevention” to be directed to the **fighthealthcarefraud** education site; at the top of the page click “Report it” and complete the “**Report Waste, Fraud and Abuse**” form
- Participating provider 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 of 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 suspected the 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 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 Claim submissions. Failure to submit medical records when requested may result in an overpayment determination and/or placement on prepayment review.
- **Prepayment Review:** Specific to a Provider or Facility under investigation, a certified professional coder in the SIU evaluates Claims prior to payment. Edits in Anthem's

Claims processing systems identify these Claims for review to prevent automatic Claims payments in specific situations.

- **Recoveries:** 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 working with the SIU, communication other than paper medical records and claims (for example, checks, correspondence) should be sent to:

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

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

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

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 Prepayment Review

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

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

When a Provider or Facility is on prepayment review, the Provider or Facility will be required to submit medical records and any other supporting documentation with each Claim so Anthem can review the appropriateness of the services billed, including the accuracy of billing and coding, as well as the sufficiency of the medical records and supporting documentation submitted. Failure to submit medical records and supporting documentation to Anthem in accordance with this requirement will result in a denial of the Claim under review. During the pendency of the prepayment review, if requested, The Provider or Facility will be given the opportunity to discussion of his/her/its prepayment review status.

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

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

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

Acting on Investigative Findings

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

Pharmacy & Prescriber Home Program

The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare Providers. 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 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 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 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

Communications to Members

Members who meet criteria are sent a notification at least 60 days prior to potential inclusion in the program. After the 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 30 additional days to select a Pharmacy and/or Prescriber Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy or Prescriber Home within the allotted timeframe, one (1) will be chosen for the Member on the 31st day based on recency and frequency of use within their Claims history. Anthem will ensure both the Member and their Provider will be notified of their new Pharmacy and/or Prescriber Home in writing. Once they have chosen a Pharmacy and/or Prescriber Home, a request to change pharmacies will be considered for good cause situations only.

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

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

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

Product Summary

Medicare Supplemental

Medicare Supplemental plans are additional insurance sold by private insurance companies such as Anthem. These plans, when combined with payments made by Medicare, are designed to reduce out-of-pocket costs for most Medicare-covered services. They are sometimes referred to as Medigap insurance. Anthem offers several Medicare Supplemental plans each with different sets of benefits and premiums.

Anthem Blue Cross and Blue Shield HMO/POS

Anthem participating Providers in Connecticut may expand their participation under the participation Agreement with Anthem to include Anthem HMO/POS Members. The following plans are available to Anthem Members with an expanded local network that includes Anthem Network/Participating Providers:

- Anthem Direct POS
- Anthem Direct HMO
- Anthem DirectShare ^{SM} POS

These Members can be identified through the prefixes of their identification cards, which are YLL, YLF, YLQ, POS, or POP.

The State of New York requires the selection of a Primary Care Physician (PCP) for Anthem HMO/POS Members, but none require referrals. The Anthem Direct HMO does not offer out-of-network services, while the other plans do offer out-of-network services subject to Member Cost Shares. While a referral from the PCP is not required to obtain services from a network specialist, some services require prior authorization.

Eligibility and Claims Status Inquiries

For Member eligibility, call: 1-800-676-BLUE (2583) or use Availity

For Claims status, call: 1-800-992-2583 or use Availity

Prior Authorization

Anthem Blue Cross and Blue Shield is the primary source for prior authorizations to Anthem HMO/POS plans. Anthem refers to prior authorization as pre-certification, and the use of this term will be used in their communications. The medical management contact information for services to an Anthem HMO/POS Member is located on the back of the Member's ID card.

If the Member is admitted to the hospital as a result of a visit to an urgent care Facility, the emergency room, or the physician's office, the Anthem Medical Management Department must be notified by the physician or the hospital within 48 hours of the admission at:

(800) 441-2411

Hours: 8:00 a.m. to 5:00 p.m.

New England Health Plans

Anthem participates in a regional managed care program, New England Health Plans, in cooperation with four other New England Blue Cross and Blue Shield plans in Maine, New Hampshire, Massachusetts and Rhode Island. In Connecticut, Members of the New England Health Plans access care from health care professionals participating in the BlueCare Health Plan Network. Anthem Blue Cross and Blue Shield's participation is twofold:

As a Home Plan – When the employer group's headquarters is located in the service area, this area's plan has the primary responsibility for selling and servicing the account.

As a Host Plan- The area in which a Member from a Home Plan account selects a PCP is responsible for Provider and medical management services for the Member.

Membership/Benefits/ Eligibility Inquires	1-800-676-BLUE
Claims Inquires	1-800-238-2465
Anthem Behavioral Health	1-800-228-5975

New England Health Plans – Utilization Management

When a New England Health Plans Member selects from the Connecticut Network, the Members care will be coordinated in accordance with the BlueCare Health Plan's UM guidelines. To coordinate appropriate approval for one of these Members, use the numbers listed below. If the Members PCP is located outside of Connecticut, call 1-800-676-BLUE to contact the Plan in the state where the PCP is located for UM requirements.

Refer to the UM section of this manual for more information on Urgent Care and Emergency Admissions Authorization.

Prior Authorization: 1-800-238-2227

- Elective Admission
- Emergency Admissions Certification
- Urgent Care/Emergency Treatment

Case Management 1-800-231-8254

Benefit Programs

HMO Blue New England:

- Requires Members to select a PCP from the Network directory in the state where the Member will be accessing Health Services. In Connecticut, Members select their PCP from the BlueCare Health Plan Network.
- Requires Members to obtain all routine care or obtain a referral from their designated PCP for Covered Services from a participating specialist.
- Allows Members to change their PCP at any time. This change will be effective the first day of the following month.

- No out of Network benefits.

Blue Choice New England Point –Of- Service (POS) program

- Requires Members to select a PCP from the Network directory in the state where the Member will be accessing Health Services. In Connecticut, Members select their PCP from the BlueCare Health Plan Network.
- Encourages Members to obtain all routine care or obtain a referral from their PCP for Covered Services from a participating specialist. By doing so, Members will pay only a small co-payment for Covered Services.
- Allows Members to self-refer to participating or non-participating specialists and still be eligible for coverage with additional cost shares and deductibles.
- Allows Members to change their PCP at any time. This change will be effective the first day of the following month.

Access Blue New England:

- Requires Members to select a PCP from the Network directory in the state where the Member will be accessing Health Services. In Connecticut, Members select their PCP from the BlueCare Health Plan Network.
- Referrals are not required for all in Network New England Access Blue participating Providers.
- Allows Members to change their PCP at any time. This change will be effective the first day of the following month.
- No out of Network benefits.

Important Networking Note on New England Health Plans:

Members who have selected a PCP from another state's Network must obtain out-of-Network referrals in order to receive care from a BlueCare Health Plan participating Provider. For example, Members who have selected a PCP from the Blue Cross and Blue Shield of Massachusetts Network will access in-Network services from participating specialty physicians or Providers in the Massachusetts Network. Likewise, Members with a BlueCare Health Plan PCP will access in-Network services from participating BlueCare Health Plan specialty physicians or Providers.

For Providers or Facilities that participate in more than one (1) state Claims should be submitted to the state where services are rendered.

Prefix Codes

Home Plan State	HMO Prefix	POS Prefix	Access Blue Prefix
Connecticut	CTN	CTP	EHF
Maine	MEN	MEP	EHG
Massachusetts	MTN	MTP	EHJ
New Hampshire	NHN	NHP	EHH

Behavioral Health Care

If a New England Health Plans Member requires behavioral Health Services, the Provider, Facility or the Member must call the number on the back of the identification card to locate a participating behavioral health physician or Provider.

Behavioral health services for a New England Health Plans Members do not require a referral from the PCP.

The Home Plan is responsible for coordinating behavioral health benefits. Providers and Facilities will be able to distinguish the Member's home plan by referring to the Prefix Codes listed above. Always send behavioral health Claims to the home plan for processing, unless and outside vendor is responsible for the behavioral health Claims. Connecticut Home Plan Members (CTN CTP) will access Anthem Behavioral Health Network, which they may do without a referral.

Prior Authorization: 1-800-238-2227

- Elective Admissions
- Emergency Admissions Certification
- Urgent Care/Emergency Treatment

Refer to the Utilization Management section of this manual for more information on Urgent Care/Emergency Admissions Authorization

Referrals (HMO Plans)

HMO Gatekeeper Plans

If a primary care physician (PCP) determines that a Member needs specialized care, he or she will authorize the Member to receive health care services from another health care Provider. A referral for specialized care is not a guarantee of coverage for those services; the service must also be covered within the terms of the Subscriber Agreement. Thus, regardless of medical necessity, no benefits will be provided for care that is not a covered service, even if performed by a PCP or by another Provider under a referral authorized by a PCP. Providers and Facilities may call the Provider Service Center to determine if a service is a covered service.

- If a PCP authorizes a referral to another Provider, the PCP must ensure the Member understands:
  - The name of the Provider to whom they are being referred
  - The period of time, the number of visits and services for which care is authorized
  - Who will schedule appointment(s) with that Provider – Member or PCP's office staff
- The referred Provider should consult with the Member's PCP if the care exceeds the initial referral for services.
- If the referred Provider recommends a Member to another Provider, the referred Provider must contact the PCP prior to any treatment so he or she can determine if that care will be authorized. Only a PCP can authorize care with another Provider.

- If the PCP authorizes these services, benefits will be provided according to the terms of the Member's Subscriber Agreement. Care that is not authorized by a PCP is not covered, unless the Member's Plan allows for coverage at a self-referred or out-of-network level. Providers may call the Provider Call Center to determine Member benefits and if a service is a covered service.
- PCPs may issue Members a copy of their referral. Members should retain this information as a confirmation of the PCP referral to see a specialist or Provider who specializes in treating their specific illness or injury.
- While most services will require a referral, some services do not; such services include but are not limited to:
    - Services from the Member's PCP
    - Online visits
    - Routine obstetrical and gynecological (ObGyn) including maternity services
    - Mental health and substance abuse services
    - Diagnostic x-rays
    - Diagnostic labs at an independent lab
    - Routine eye exams
    - Medical emergency conditions
    - Walk-in centers
    - Retail health clinics
- Providers may call the Provider Call Center to determine Member benefits and to confirm when a referral is required. Referrals do not take the place of prior authorizations. Prior authorizations will need to be obtained when mandated by the benefit plan.
- Note: If a PCP determines a Member does not need a referral and the Member disagrees, the Member has the right to appeal the decision. The Member's Subscriber Agreement outlines the necessary steps in submitting an appeal.

Referrals to in-network specialists

PCPs may refer Members to in-network specialists. Referrals to in-network specialists are required for HMO gatekeeper plans.

Referral to non-network Providers

At times, a Member may require services that are not available from Providers or Facilities within the network. A PCP may make a referral to an out-of-network Provider. Referrals to an out-of-network Provider must be pre-approved by Anthem for services to be reimbursed.

Standing referrals

A Member with a special condition requiring ongoing care from a specialist may receive a standing referral to a specialist for treatment of the special condition from the Member's PCP. A special condition is a condition or disease that is life-threatening, degenerative, or disabling and requires specialized medical care over a prolonged period of time. A standing referral must be

made according to a treatment plan, approved by Anthem's Medical Director in consultation with the Member's PCP.

Health Insurance Marketplace (Exchanges)

The Affordable Care Act (ACA) authorized the creation of Health Insurance Marketplaces (commonly referred to as Exchanges) to help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans.

Anthem offers qualified health plans on the Individual or Small Business Health Options Program (SHOP) Exchange in many states, as well as health plans not purchased on public exchanges. Qualified health plans on the Individual and SHOP Exchange follow the same policies and protocols within this Provider Manual, unless otherwise stated in the Provider or Facility Agreement.

Updates about Anthem's ACA compliant health plans and the networks supporting these plans are published in Anthem's Provider newsletter, and sent via Anthem's email service.

To access the newsletter, go to **anthem.com/provider/news** and select your state. The option to sign up for Provider Communications updates is also on this page.

Important reminder:

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

Federal Employees Health Benefits Program (FEHBP)

FEHBP Requirements

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

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

Submission of Claims under the FEHBP

All Claims under the FEHBP must be submitted to Plan for payment within the timeframe listed in the Provider or Facility Agreement. This timeframe applies from the date of discharge or from the date of the primary 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 thirty (30) calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the Claim. If the additional information is not received within sixty (60) calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the Plan does not completely satisfy the Member's request, the Plan will advise the Member of their right to appeal to OPM.

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

FEHBP Formal Provider and Facility Appeals

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

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 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 months of the date of the local Plan's final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

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

FEHBP Inpatient Skilled Nursing Facility Care

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

Online information for FEHBP

Refer to the benefits and services on the FEHBP Website **fepblue.org** for additional information.

BlueCard® Program Overview

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

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual online. Go to **anthem.com**, select **For Providers** and choose **Connecticut**, select **Policies, Guidelines & Manuals** under Provider Resources, scroll down and select "**Download the Manual**", then scroll to the Provider Manual Library section and choose **BlueCard Provider Manual**. **BlueCard Provider Manual Link**

Medicare Advantage

Refer to the Medicare Advantage website for additional information at **anthem.com/medicareprovider**

Medicare Advantage Provider Manuals are available on Anthem.com. Select **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

Useful Links

Anthem's Website for Members, Providers and Facilities
www.anthem.com

Contact Us Phone Numbers and Quick Reference Guides:
https://www.anthem.com/provider/contact-us/

Medicare Eligible:
https://www.anthem.com/provider/medicare-advantage/

Blue Cross Blue Shield Association
www.bcbs.com

Federal Employee Program
http://www.fepblue.org/index.html

Availity Portal
www.availity.com

National Uniform Billing Committee (NUBC)
www.nubc.org