Facility Manual

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November 2016

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Using This Manual

The Anthem Blue Cross (Anthem) Facility Provider Manual (alternatively referred to herein and in your Provider Agreement as the "Hospital Operations Manual," "Provider Operations Manual," "Provider Manual," "Operations Manual," or the "Manual") is a comprehensive document designed to inform Facilities of Anthem's guidelines and requirements. All of the processes and procedures set forth in this Manual shall become effective March 1, 2017, and are applicable to all claims submitted on or after the effective date of the Manual.

This Manual applies to Facilities contracted under the *Anthem Blue Cross Comprehensive Contracting Hospital Agreement,* any *Anthem Blue Cross Facility Agreement* or *Anthem Blue Cross Mental Health Participating Hospital/Facility Agreement* (Agreement). To the extent that any of the provisions in this Manual conflict with the terms of your Provider Agreement with Anthem, the Provider Agreement takes precedence over the Manual. Throughout this Manual, any references to the Provider Agreement shall be meant to refer to those listed above unless otherwise indicated.

Throughout the Manual;

- Anthem Blue Cross may be referred to as Anthem Blue Cross or Anthem.
- Any reference to Provider also means "Facility," "Hospital" and "Non-Hospital Facility."
- Any reference of Member also means "Covered Individual."

BlueCard® Program

For information specific to the BlueCard Program see section *BlueCard* and the BlueCard Provider Manual online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.

Federal Employees Health Benefits Program

For information specific to Federal Employee Program (FEP), see section *Federal Employees Health Benefits Program*, (FEHBP) of this Manual.

Medicare Advantage

! In this version of the Manual, for information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook. Or, refer to the *Medicare Advantage* section of this Manual.

Transplant

For information specific to transplant see section *Centers of Medical Excellence* and the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual*, which can be found in the *Exhibits* section.

Manual Search Tool

There may be times when Manual users need to search for items throughout the entire Manual. Adobe® Acrobat, the file format used for this Manual, has a search feature that allows for this type of search. To use this feature, refer to the "Manual Search Tool" located in the *Exhibits* section of this Manual.

For quick access to specific information, refer to the *Table of Contents*.

Purpose and Introduction

We appreciate your participation in Anthem's Provider Network. Anthem is committed to working with Facilities and Members to provide a high level of satisfaction in delivering quality care. The *Anthem Blue Cross Facility Manual* is an integral part of this commitment, providing information on key contractual terms, products, eligibility, admissions procedures and related certification requirements, claims submission, Utilization Management guidelines, and a directory of resources.

! This Manual is developed for our Facilities who submit Claims using the *UB-04 Claim* type.

In summary, this Manual communicates administrative and billing requirements. As Anthem makes changes to these requirements, this Manual will serve as a vehicle for communicating these changes.

Note: A **bold** exclamation point "**!**" will be used to indicate that this information is important to understand, but may not be obvious. If you see this symbol, pay careful attention to the information.

For quick access to specific billing requirements and related information, refer to the *Table of Contents*.

Future Updates

Anthem is committed to providing contracted Facilities with an accurate and up-to-date Manual. There may be instances where new procedures or processes are not immediately reflected in the Manual. In such cases, Anthem will **send a 90-day Provider notification** and publish the most current procedures and policies as an "Update to the Manual" on ProviderAccess®. Anthem will make every effort to include the update in the next Manual update.

! IMPORTANT UPDATE REGARDING PROVIDERACCESS®
Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. **No further registration is needed if you have already registered with Availity.**

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth.

For more information about the Availity Web Portal, refer to the *Availity Web Portal (Availity)* section in this Manual.

Included in This Manual

This Manual is divided into the following 38 sections:

1. Introduction and Guide to Manual

This section defines the purpose of the Manual, includes a brief description of the sections contained in the Manual, and provides a summary of updated and new information in this revision of the Manual.

2. Legal and Administrative Requirements Overview

This section provides an overview of some of the legal requirements with which Facilities need to comply. It is not intended to be a comprehensive or complete listing. Facilities should consult with their own legal counsel for advice and direction.

3. Directory of Services

This section provides contact information for personnel who are available to address your inquiries regarding claims, eligibility and benefits, and quality management just to name a few.

4. Availity Web Portal (Availity)

This section introduces ProviderAccess and Availity. Access to these websites is 24/7 for your convenience.

5. Eligibility

This section addresses a variety of criteria used to determine eligibility and benefits including Availity, the exclusive web portal for Anthem health care professionals. In addition, sample health care identification (HCID) cards are displayed for your reference.

6. Admissions Process

This section provides information concerning the admissions about which each Facility should be aware. Admissions are one component of Anthem Medical Management program, which addresses the appropriate utilization of Facility services.

7. Claims Submission

This section provides general billing guidelines and claim submission requirements. It also identifies the more common situations that result in returned or rejected claims and processing delays due to returned or rejected claims. An overview of electronic billing and information on whom to contact about Electronic Data Interchange (EDI) products and services is also included. Information for Contracting Providers on Claims Settlement Practices was updated.

8. Reimbursement Policies

This section provides information on reimbursement, overpayment and recovery, pricing methods, and remittance of adjudicated claims. Also discussed are other reimbursement sources from which a Facility may seek payment (e.g., third-party liability/Workers' Compensation and Members' liability).

9. Medical Policy

This section describes the medical policy and clinical Utilization Management (UM) guideline formation process.

10. Medical Management Program

This section explains the Utilization Management (UM) programs, including the medical necessity review process, access to decision-making criteria, pre-service review, continued stay review, discharge planning, post-service review, Care Management (Case Management/Disease Management CM/DM) and Behavioral Health Management. This section also addresses Facility responsibilities, referrals to nonparticipating Providers, review initiation, Peer Clinical Reviewers, and the on-site UM program.

11. Credentialing

This section describes Anthem's credentialing process for all contracted Health Delivery Organizations (HDOs).

12. Quality Improvement Program

The Quality Improvement Programs are discussed in detail, including patient safety and continuity and coordination of care.

13. Cultural Diversity and Linguistic Services

This section recognizes that Providers and Facilities can encounter challenges when delivering health care services to a diverse population.

14. Health and Wellness

This section describes some of the Health and Wellness programs available to Anthem group health plan Members, such as Future Moms (Maternity Management) and ConditionCare (Disease Management). The current ConditionCare programs include asthma, chronic obstructive pulmonary disease (COPD), heart failure, coronary artery disease (CAD) and diabetes (type 1 and 2).

15. Centers of Medical Excellence

This section describes the Anthem Centers of Medical Excellence (CME) for transplants and other approved procedures.

16. Members Grievance and Appeal Process

This section addresses the grievances and appeals process established by Anthem to investigate and resolve Members' appeals as well as complaints related to the quality of care and service provided by plan health care professionals. This process is in compliance with regulatory, statutory and accreditation requirements.

17. Dispute Resolution Process for Contracted Providers

This section describes Provider dispute and resolution process, including meet and confer.

18. Product Summary

This section contains summaries of a broad variety of Anthem managed care products, enhancements and benefits, including PPO, HMO, POS, Behavioral Health, pharmacy and Workers' Compensation products.

19. Medicare Advantage

This section provides an overview of the Medicare Advantage Products offered by Anthem.

20. Medicare Crossover

This section describes duplicate claims handling for Medicare Crossover.

21. Federal Employees Health Benefits Program

This section outlines the specific language for the Federal Employees Health Benefits Program (FEHBP), also known as Federal Employee Program (FEP).

22. BlueCard® Program

This section describes the BlueCard Program.

23. Health Insurance Marketplace (Exchange)

The Affordable Care Act (ACA) calls for the development of health plans offered on Health Insurance Marketplaces (commonly referred to as exchanges), as well as health plans not purchased on public exchanges.

24. Audit

This section describes Anthem's Audit Policy.

25. Fraud, Waste and Abuse Detection

This section describes the detection of fraud and abuse in accordance with applicable State and Federal law.

26. Glossary

This section defines the terms used in the Agreement and throughout the Manual. These terms describe various products, contracted Providers, organizations and specialized services that relate to managed care services.

27. Exhibits

This section displays all exhibits referenced in this Manual.

28. Appendix A – Network Leasing Arrangements

This appendix describes network-leasing arrangements and provides a link to a list of Other Payors.

29. Links

This section provides website addresses in alphabetical order.

30. Workers' Compensation

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31. Skilled Nursing Facility

This section outlines general and specific billing guidelines for Skilled Nursing Facility Providers.

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This section outlines general and specific billing guidelines for Dialysis Facilities.

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This section outlines general and specific billing guidelines for Hospital-based Home Infusion Therapy Providers.

34. Home Health Agencies

This section outlines general and specific billing guidelines for Home Health Agencies.

35. Hospice

This section outlines general and specific billing guidelines for Hospice Providers.

36. Ambulatory Surgical Center

This section outlines general and specific billing guidelines for Ambulatory Surgical Centers.

37. Behavioral Health and Substance Abuse

This section outlines general and specific billing guidelines for Behavioral Health and Substance Abuse Mental Health Facilities.

38. Summary of Material Changes

The Summary of Material Changes table provides a summary of new and updated information for this year's revision of the Manual, and is organized by section. The changes outlined in the table will take effect March 1, 2017

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Introduction

This section provides an overview of some of the legal requirements with which Facilities must comply. It is not intended to be a comprehensive or complete listing. Facilities should consult with their own legal counsel for advice and direction.

Facility Notification Responsibilities

Anthem Blue Cross (Anthem) has established information guidelines that Facilities must keep current. The Facility must promptly notify the Anthem Network Relations department of the following:

1. Any change in its business ownership.
2. Any business address change or address change of locations where services are provided by the Facility.
3. Any legal or governmental action initiated against the Facility, including, but not limited to, an action:
   a. For professional negligence.
   b. For violation of the law.
   c. Against any accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or any successor, or any license, which, if successful, would materially impair the Facility's ability to carry out the duties and obligations under its Agreement.
4. Any other problem or situation that will impair the Facility's ability to carry out the duties and obligations of its Agreement.
5. Any reduction or elimination of emergency services; Facilities must give 90-day prior notice to state and local governments, contracted health plans, and the public.
6. Any reduction of insurance or cancellation for professional liability or comprehensive general liability; Facilities must give 10-day prior notice to Anthem.

SB 137 Anthem Provider Directory

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

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

Participating Facilities must respond timely to Anthem's regular or follow-up outreach to confirm Provider directory information.

Misrouted Protected Health Information (PHI)

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 Facility is not currently treating. PHI can be misrouted to Facilities by mail, Fax, email, or File Transfer Protocol (FTP). Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Facilities permitted to misuse or re-disclose misrouted PHI. If Facilities cannot destroy or safeguard misrouted PHI, Facilities must contact Network Relations by email CAContractSupport@Anthem.com to report receipt of misrouted PHI.

! *Contractual Requirements*

It is the responsibility of all our contracted Facilities to protect the confidentiality of Members health information at all times, in accordance with current statutory, regulatory and accreditation requirements. Anthem also preserves the confidentiality of our Members personal and medical information, in accordance with current statutory, regulatory and accreditation requirements. Anthem contracts further require that:

- Facilities contracted with Anthem must cooperate with Anthem Quality Improvement (QI) program activities.
- Facilities may freely communicate with patients about their treatment, regardless of benefit coverage limitations.
- Anthem has access to Facility medical records to the extent permitted by state and federal law and per the Agreement.

General Acute Care Hospitals: Interpreters

Section 1259 of the *California Health and Safety Code* requires general acute care Hospitals to implement policies and procedures to address language barriers, including the hearing impaired, between patients and professional staff. Specifically, *H&S Code 1259* requires:

- Arrangements for interpreters or bilingual professional staff to address language barriers between patients and staff.
- Development and posting in conspicuous locations, notices of available interpreter services, and a Telecommunications Device for the Deaf (TDD) number for the hearing impaired.
- Identification of the patient's primary language and dialect on one or more of the following: patient medical chart, Hospital bracelet, bedside notice or nursing card.
- Preparation and maintenance of, as needed, a list of proficient interpreters including sign language.
- Notification to employees of the Hospital's commitment to provide interpreters to all patients who request them.
- Review of all standardized written forms, waivers, documents and informational materials available to patients upon admission to determine which to translate into languages other than English.

- Consideration to provide its non-bilingual staff with standardized picture and phrase sheets for use in routine communications with patients who have communication barriers.
- Consideration to develop community liaison groups to enable the Hospital and the limited-English-speaking and hearing-impaired communities to ensure the adequacy of the interpreter services.
- Annual review of the general acute care Hospital's policy for language assistance to ensure procedures are in place to provide timely access to interpreter services when a language barrier exists 24 hours per day.
- Annual transmission to the state department of updated policies and a description of efforts to ensure adequate and timely communication between patients with language barriers and staff.

Insurance Requirements

A. Network/Participating Providers shall, during the term of this Agreement, keep in force with insurers having an A.M. Best rating of A minus or better, or self-insure the following coverage:

   1. Professional liability/medical malpractice liability insurance limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap. Notwithstanding the foregoing, in no event shall such professional/liability medical malpractice liability insurance limit be less than $1,000,000 per claim and $3,000,000 in the aggregate.

      If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Network/Participating Provider agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years in the amount not less than the per claim and aggregate values indicated above.
   2. Workers' Compensation coverage with statutory limits and Employers Liability insurance.
   3. Commercial general liability insurance for Providers and Facilities with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate for bodily injury and property damage, including personal injury and contractual liability coverage.

   For Ambulance/Medical Transportation Providers Only, in addition to the above:

   - Auto Liability insurance, which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors, or omissions in the rendering or failure to render services, but at no time shall total limits be less than $500,000 combined single limit.

   For Air Ambulance Providers Only, in addition to the above:

   - Aviation Liability insurance with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate.

Acceptable self-insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured Network/Participating Provider shall maintain and provide evidence of a valid self-insurance program consisting of at least one of the following upon request:

1. Actuarially validated reserve adequacy for incurred Claims, incurred but not reported Claims and future Claims based on past experience;
2. Designated claim third-party administrator or appropriately licensed and employed claims professional or attorney;
3. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.

B. Provider and Facilities shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. A certificate of insurance shall be provided to Anthem upon execution of this Agreement and upon request execution of this Agreement and upon.

Third Party Administrator (TPA)

Claims Dispute Regulations do not apply to TPA groups because they are self-insured; TPAs should follow the normal grievance and appeal procedures. TPA groups must comply with Employee Retirement Income Security Act (ERISA).

Requests for Disclosure of Medical Information

State law authorizes an adult patient to prepare a specific addendum to his or her patient records, and requires health care Providers to attach that addendum to the patient's records. It also requires that the person or entity seeking to obtain medical information must obtain authorization from the patient (unless the disclosure is allowed by law without authorization). It further prohibits plan contractors, corporations, or their subsidiaries and affiliates from intentionally sharing, selling, or using any medical information for any purpose not necessary to providing health care services to the Member. Anthem offers the *Member Authorization Form* for Providers to use when releasing PHI to Anthem. The form is available on the company's public website at anthem.com/ca > Menu > Forms > Member Authorization Form and in the *Exhibits* section of this Manual.

Electronic Data Transactions

HIPAA mandates standards for Electronic Data Interchange (EDI) transactions and code sets. It establishes uniform health care identifiers for health care professionals, health plans and employers. It also addresses privacy and security issues. For updates regarding HIPAA, including the *HIPAA Readiness Disclosure Statement*, refer to the ProviderAccess website.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017.

Note: Refer to *Exhibits* section for our *Notice of Privacy Practices*.

Use of Social Security Numbers

Per state law, insurers are prohibited from using an individual's Social Security Number in certain ways, including posting it publicly or requiring it for access to products or services.

The collection, use or retention of Social Security Numbers as required by state or federal law or the use of Social Security Numbers for internal verification or administrative purposes is not prohibited. The opening of certain records that must be accessible to the public, pursuant to specified state laws, is still allowed.

Health care service plans and health care service physicians, Hospitals, Facilities, other health care professionals, pharmacy benefits managers, or contractors (hereinafter called health care entities) are prohibited from:

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

Regulation and Accreditation Requirements

Participating Facilities are required to comply with all regulatory and accrediting requirements. This includes the Federal ERISA requirements that have been in effect since 2003. Traditionally, the ERISA regulation sets minimum standards for most voluntarily established pension and welfare benefit plans in private industry, in order to provide protection for individuals in these plans.

- Plans must provide participants with important information about plan features and funding.
- Plans must establish a claims and appeal process for participants to get benefits from their plans.
- ERISA provides fiduciary responsibilities for those who manage and control plan assets.
- ERISA gives participants the right to sue for benefits and for breaches of fiduciary duty.

ERISA also governs health care plans offered by employers that self-fund their health benefits (e.g., firms that use their own funds to cover employee health claims). By self-funding under ERISA, employers are able to exempt their health plans from state insurance regulation.

An ERISA flag on the electronic eligibility report identifies Members when their respective plan becomes effective.

ERISA categorizes claims as follows:

- Urgent care
- Pre-service requests (timeframes for authorization requests, denial notices, access to information, etc.)
- Concurrent care requests (timeframes for authorization, reduction/termination of care previously approved, denial notices, etc.)
- Post-service requests (timeframes for payment, timeframes for authorization, denial notices, etc.)

- Appeals (timeframes for review, denial notices, limit on levels of appeal, limit on mandatory arbitration, level review requirements, etc.)

ERISA has an effect on the procedures by which a claim must be processed, as well as the processes under which authorization for services is given.

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 based on the health status of Members who are insured under small group or individual health benefit plans compliant with the Affordable Care Act (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 ICD-10 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 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 Affordable Care Act. 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.

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 physicians to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the Provider 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).
- The documentation describing the condition and MEAT 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 signature, credentials and date must appear on record and must be legible.

! *Continuity of Care/Transition of Care*

California law provides for the rights of certain Members to have a smooth transition to a new Provider and to complete a course of treatment with the same Provider, or to maintain the same Provider under certain circumstances.

Refer to the *Medical Management Program* section under subsection *Continuity of Care/Transition of Care*.

Compliance with Laws: Disability Access

Facilities shall comply with all applicable state and federal laws and regulations, including those governing access to health care Facilities for people with disabilities.

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Introduction

This section provides a directory of contacts to help health care professionals access the resources they need at Anthem Blue Cross (Anthem). The directory identifies service units and Anthem personnel that have the required expertise to address questions, issues and concerns.

AIM Specialty Health (AIM) Call Center

Area	Telephone Number	Website
AIM Specialty Health (AIM Call Center) (elective non-emergency diagnostic imaging procedures)	1-877-291-0360 (Authorization only) 1-866-677-6669 (Claims issues only)	ProviderAccess® provider2.anthem.com/wps/portal/ebpmybcc OR Anthem.com/ca > Providers > Enter > Login Once logged into ProviderAccess, select "Referrals & Pre-auths" then "Imaging and Specialty Drug Requests"

AIM Operating Schedule	
Monday through Friday	7 am to 5 pm PST
AIM's ProviderPortal℠	Available 24 hours a day, seven days a week

For more information about Anthem's relationship with AIM, see the *Medical Management Programs* section of this Manual.

Anthem Blue Cross Life and Health Insurance Company

Area	Telephone Number
Anthem Blue Cross Life and Health Insurance Company	1-800-274-7767

Anthem Center for Medical Excellence for Transplant

Area	Fax Number	Telephone Number
Transplant	1-877-264-4540	1-888-574-7215

Availity Web Portal (Availity)

Availity Web Portal is a secure, single sign-on, multiple payer website that provides access to view eligibility and benefits inquiry, claim status inquiry, online preauthorization, claim submission, and much more.

Availity Web Portal Client Services	
Availity Client Services is the best resource to assist with any questions about the registration process on Availity, logon credentials and technical support. **Need training?** Login to Availity and view the current training resources. Select the **Help** tab found at the top right corner of the page, then select the appropriate link from the drop-down.	availity.com 1-800-AVAILITY (282-4548) toll free (Monday through Friday) 5 am to 4 pm PST

Behavioral Health Care Management/Utilization Review

Not all plans require preauthorization or Case Management/Utilization Review. Use Interactive Care Reviewer (ICR) through Availity or call Customer Service to determine benefits, eligibility and authorization requirements. Below is the telephone number for preauthorization or Care Management/Utilization Review for Behavioral Health.

Note: Most ABA services require preauthorization. Contact Behavioral Health UM to request preauthorization before initiating ABA treatment with Anthem Members. Not all Anthem Members are covered for ABA. Call customer care at the number on the back of the Member's ID card to confirm benefits and eligibility.

Service Area	Telephone Number
Behavioral Health Care Management/Utilization Review	1-800-274-7767
Mailing Address	**Fax Number**
Anthem Blue Cross Behavioral Health Attn: Care Management P.O. Box 600188 San Diego, CA 92160	1-877-521-4787

Behavioral Health Network Medical Director

Access to the Behavioral Health Medical Director
To speak with the Behavioral Health Medical Director, call 1-858-571-8129

Behavioral Health Network Relations

Behavioral Health Network Relations is the liaison between Anthem and participating Behavioral Health individual Providers, Groups and Facilities. Network Relations associates provide contracting support for questions such as rate (fee) schedules, contract (Agreement) language or requirements as specified in the Manual. Send all inquiries to the Behavioral Health Network Relations team by email.

Email Address
BHNetworkRelations@anthem.com

When emailing an inquiry, include the following information:

- Provider, Group, or Facility tax identification number(s)
- Provider, Group, or Facility NPI number
- Provider's name and license number
- Complete contact name (company name, if not the same as Provider) and phone number, including extension number
- Detailed description of your question or inquiry

Behavioral Health Provider Resources

The Web page, Behavioral Health Provider Resources is a comprehensive resource link to specific behavioral health information.

- Announcements
- Behavioral Health Forms
- Resources and Support
- Plans, Programs and Benefits
- Policies, Guidelines and Tool Kits
- Communications and Updates

Go to anthem.com/ca, select the Providers link at the bottom of the page. When the Landing page displays, scroll down to *Learn More*, select the link, Behavioral Health Provider Resources. For direct access to the Web page visit the *Links* section in this Manual. For assistance, email Behavioral Health Network Relations at BHNetworkRelations@anthem.com.

BlueCard® Eligibility and Membership Contact Information

Area/Contact	Telephone Number	Mailing Address
BlueCard (Out-Of-Area)	1-800-676-BLUE (2583) (Eligibility & Membership only) 1-800-444-2726 (Claim Status only)	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007

Area/Contact	Telephone Number
BlueCard® PPO Information about participating Providers, Hospitals, Facilities or other health care professionals	1-800-810-BLUE (2583)
Blue Cross and Blue Shield Eligibility & Benefits (out of area) Monday through Friday, 4:30 am to 5 pm PST	1-800-676-BLUE (2583)

California Department of Insurance

The California Department of Insurance (CDI) regulates insurers. Anthem Blue Cross Life and Health Insurance Company is regulated by the CDI. Anthem Blue Cross Life and Health Insurance Company Members should be directed to contact Anthem Blue Cross Life and Health if they have a question or complaint. If the problem is not resolved, they can either call toll free or email the CDI.

Area	Telephone Number
Inside California	1-800-927-HELP (4357)
Outside California	1-213-897-8921
Mailing Address	**Email Address**
Sacramento Office 300 Capitol Mall, Suite 1700 Sacramento, CA 95814 San Francisco Office 45 Fremont Street, 23rd Floor San Francisco, CA 94105 Los Angeles Office 300 South Spring Street, South Tower Los Angeles, CA 90013	"Consumer Services" link at insurance.ca.gov

California Department of Managed Health Care

The California Department of Managed Health Care (DMHC) is responsible for regulating health care service plans. For more information on grievance procedures, see the *Member Grievance and Appeals Process* section in this Manual.

Mailing Address
Department of Managed Health Care 980 9th Street, Suite 500 Sacramento, CA 95814-2724

Service Area	Telephone Number
Consumer Independent Medical Review/Complaint Requests	1-888-466-2219 1-916-255-5241 (Fax)
DMHC internal TDD line	1-877-688-9891 (TDD)
Health Plans and Providers	Voice: 1-916-324-8176 Toll-free Provider complaint line: 1-877-525-1295 Email: plans-providers@dmhc.ca.gov

California Public Employees Retirement System (CalPERS)

Area	Telephone Number
CalPERS	1-800-451-6780

Case Management/Disease Management

Commercial Case Management Unit	Telephone and Fax Number
Case Management/Disease Management Commercial HMO/PPO Anthem Blue Cross Attn: Case Management P.O. Box 4307 Woodland Hills, CA 91365-4037	1-888-613-1130 1-800-947-4074 (Fax) Case.Management@anthem.com (Email)
Transplant Case Management	1-888-574-7215 1-877-264-4540 (Fax)
Senior Secure Case Management	1-866-797-9884 1-404-467-2955 (Fax)

Claims and Correspondence Mailing Addresses

Anthem Blue Cross uses the following mailing addresses for Claims and Claims-related correspondence:

Service Area	Mailing Address	
All Claims and Claims-related correspondence, except for Federal Employee Program (FEP)	Anthem Blue Cross P.O. Box 60007 Los Angeles, CA 90060-0007	
Federal Employee Program (FEP) All **professional Claims** and Claims-related correspondence go to Blue Shield All **Facility Claims** and Claims-related correspondence go to Anthem Blue Cross	Blue Shield of California P.O. Box 272510 Chico, California 95927	Anthem Blue Cross P.O. Box 105557 Atlanta, GA 30348-5557
Claims and correspondence via Federal Express, registered or certified mail, etc.	Anthem Blue Cross/Name of Product 21555 Oxnard Street Woodland Hills, CA 91367	
Workers' Compensation – all related correspondence. Claims should be submitted directly to the Workers' Compensation Payor.	Anthem Workers' Compensation P.O. Box 70022 Anaheim, CA 92825-0022	

Customer Service

All inquiries from Anthem Members should be directed to the Customer Service department. In addition, Customer Service representatives assist Providers with a variety of administrative issues, including:

- Eligibility verification and research
- Benefit questions and explanations (except transplant)
- Confirming if authorization or Utilization Management is required for services
- Requests for Members removal following disciplinary actions
- Claim status
- Claims address

Providers can access most Customer Service resources through the Provider Care Department (PCD), Anthem's virtual call center. This call center simplifies our systems by incorporating first-contact resolution with best practices to act as a dedicated single point of contact just for Providers. See the *Provider Care* subsection of this section for more information.

Area	Telephone Number
Provider Care	Call the phone number on the Member ID card.

Employee Assistance Program

Hours of Operation	Telephone Number	Email and Web Address
Monday through Friday 7 am to 4 pm PST	1-888-650-5748	EAPProviderNetworks@Anthem.com AnthemEAP.com

E-Solutions

For more information pertaining to sending and receiving HIPAA compliant Claims, electronic remittance advices (ERA), electronic Claims payments (EFT) and eligibility and Claims status via Electronic Data Interchange (EDI), contact an EDI Specialist.

EDI Solutions	
Hours available	8 am to 4:30 pm PST
Live Chat	anthem.com/edi – Select "California"
Telephone	1-800-470-9630
Website Address	anthem.com/edi – Select "California"
Email Address	e-solutions.support@anthem.com

Should Provider elect to receive payments via EFT, such election may be deemed effective by Anthem for any Claim your Agreement with Anthem pertains to. Anthem may share information about Providers, including banking information, with third parties to facilitate the transfer of funds to Provider accounts.

The e-Solutions support area assists with EDI products and services. For more information about EDI, refer to the *Claims Submission* section of this Manual.

Grievances and Appeals

Behavioral Health Grievances & Appeals Department

Mailing Address	Telephone	Fax
Anthem Blue Cross Behavioral Health Grievances & Appeals P.O. Box 4310 Woodland Hills, CA 91367-4310	800-227-3851 ext. 818-234-3500 TDD 1-866-333-4823	1-877-487-7394

HMO and PPO: Members

Mailing Address	Telephone	Fax
Anthem Blue Cross Grievances and Appeals P.O. Box 4310 Woodland Hills, CA 91367-4310	1-800-365-0609 TDD 1-866-333-4823	1-818-234-1089

Medical Provider Network (MPN) Members must call the Anthem Workers' Compensation MPN Services at 1-866-700-2168 toll free.

Area (Physician) Contact	Telephone
Anthem Blue Cross Grievances and Appeals Joseph A. Karam, MD, Medical Director	1-818-438-7351
Behavioral Health Grievances and Appeals Robert Friedman, MD, Medical Director	1-858-571-8129

Language Assistance Program

At Anthem Blue Cross (Anthem), we believe in the strength and value of cultural diversity. We realize that communication with physicians and other health care professionals is paramount to ensuring optimum health and wellness. To facilitate communication, we offer interpretation services to eligible Members at no cost. Certain Members are excluded from the Language Assistance Program, such as those under an ASO (administrative services only) plan. In addition, translated documents will be provided to Members in the languages required by the language assistance regulations.

Translation

To ensure the timely translation of materials, encourage the Member to contact Anthem by calling toll-free 1-888-254-2721. Alternately, you can call Anthem toll-free at 1-800-677-6669 to request translation on the Member's behalf.

Interpretation

To assist a Member in accessing an interpreter during regular business hours, instruct your Anthem patient to call the Customer Service telephone number located on his or her membership ID card. Alternatively, Providers may call Provider Care toll-free at 1-800-677-6669 and request to speak to an interpreter.

Medical Policy & Technology Assessment

Contact	Telephone Number
Office of Medical Policy & Technology Assessment Alan Rosenberg, MD Vice President, Medical and Clinical Pharmacy Policy	1-312-234-7026

Health & Wellness Programs

Anthem seeks to improve the lives of the Members we serve. Anthem provides a unique blend of health and wellness programs to help Members reach their total well-being goals. A quick overview of the Health & Wellness programs and services Anthem offers is available by going to the anthem.com/ca and selecting Health and Wellness.

National Provider Solutions (NPS)

The National Provider Solutions (NPS) department is responsible for handling professional, Facility and specialty network development, contracting and services.

Contract Management

The National Provider Solutions (NPS) department assigns a contract manager to act as a liaison between the physician, Hospital, Facility or other health care professional and Anthem Blue Cross (Anthem). The contract manager is responsible for:

- Maintaining contractual relationships with Hospitals
- Arranging status meetings with the administrator and/or staff of a physician, Hospital, Facility or other health care professional to resolve any outstanding issues
- Identifying new network expansion sites and managing negotiations to recruit prospective physicians, Hospitals, Facilities or other health care professionals
- Working with Quality Management Operations to monitor the physician's, Hospital's, Facility's or other health care professional's Quality Management programs
- Keeping abreast of new group enrollment and any other issues that may affect Health Care Management
- Managing the contracting staff regarding agreements, Hospital discounts and other issues related to physician, Hospital, Facility or other health care professional networks

Network Management

National Provider Solutions (NPS) assigns a Network Support Manager to act as a liaison between the Provider community and Anthem. The Network Support Manager is responsible for:

- Maintaining operational relationships with Hospitals.
- Arranging ad-hoc meetings with the administrator and/or Hospital, Facility, to address and resolve any outstanding issues.
- Working with Quality Management Operations to monitor Provider quality management programs.
- Working with internal teams to establish and address needs for resolving systemic operational issues to improve Provider outcomes and objectives.
- Keeping abreast of new group enrollment and any other issues that may affect Network Services.
- Arranging and facilitating regularly scheduled Joint Operations Committee meetings, introducing new products and programs.

Network Relations Services

Network Services is the liaison between Anthem and participating Providers. Network Services associates are available to assist you with contract interpretation questions, on-site visits and issue resolution that requires escalation (i.e., normal channels for resolving issues have been exhausted).

! NOTE: For Behavioral Health, select the link, *Behavioral Health Network Relations*.

Email Address
CAcontractsupport@anthem.com

If you would like to email your inquiry, include the following information to expedite our response to you:

- Provider's tax identification number(s)
- Medical groups, physician's and institution's nine-digit tax ID number
- Institutions should also provide their six-digit Medicare ID number
- Provider's name and address
- Complete contact name (company name, if not the same as Provider) and phone number, including extension number

When applicable, also provide:

- Patient's name
- Patient's Health Care Identification (HCID) number
- Dates of service
- Total charges

Network Services can respond to questions or complaints regarding Anthem operations and policies including, but not limited to, Claims reporting and eligibility questions.

Include the information below when sending correspondence to Anthem:

Mailing Address
Anthem Blue Cross Attn: [Anthem Blue Cross Name of Product] Specific Department 21555 Oxnard Street Woodland Hills, CA 91367

Overpayment Recovery Procedures

The following Customer Service numbers are available for overpayment recovery inquiries:

Service Area	Telephone
Large Group	1-818-234-3289
Individual Plans	1-818-234-3289
Small Group	1-818-234-3289
BlueCard®	1-800-444-2726
FEP	1-800-824-8839

Pharmacy Management

Contact	Telephone Number
Formulary Request	1-800-700-2541
Management Customer Service	1-800-700-2541
Prior Authorization of Pharmacy Benefits (PAB) Program Center	1-866-310-3666 1-877-327-8009 (Fax)
Drug List	1-800-870-6419 (for a Fax form and a list of specialty drugs)
Customer Service	1-800-870-6419 For speech and hearing impaired assistance 1-800-221-6915 (TDD/TTY)

Preventive Health Services

Anthem Blue Cross (Anthem) offers physicians the opportunity to order educational materials and other resources to support patient education interventions. Updated information and articles about health education and preventive care guidelines are available on the Internet at anthem.com/ca.

Area/Contact	Telephone Number
Preventive Health Services Beena Thomas, Director	1-404-467-2911, ext. 72911

ProviderAccess®

ProviderAccess®	
ProviderAccess® secure website	provider2.anthem.com/wps/portal/ebpmybcc
Login and technical support with registration, account Administrator changes, technical support, password resets or access issues	1-866-755-2680 Email: provideraccess.pins@anthem.com Monday through Friday 5 am to 5 pm PST

! IMPORTANT UPDATE REGARDING PROVIDERACCESS®
Anthem is targeting January 20, 2017 to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). **This change does not affect the anthem.com/ca public website.**

If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. **No further registration is needed if you have already registered with Availity.**

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth. Refer to *Availity* in this section.

Provider Care

Service Area	Telephone Number
Provider Care Department	Call the contact numbers on the back of the Member's ID Card
Provider Care Customer Service Operating Schedule	
Monday through Friday, 7:30 am to 5 pm PST **For speech-and hearing-impaired assistance:** Monday through Friday, 7:30 am to 5 pm PST	

Provider Care assists the Hospitals and medical groups with a variety of administrative issues, including:

- Eligibility verification and research
- Benefits questions and explanations
- Request for removing Members because of disciplinary problems

Contact the following areas directly for assistance:

Department	Service Unit	Telephone
Anthem Blue Cross Federal Employee Program (FEP)	Customer Service	1-800-322-7319 (Hospital Claims) 1-800-824-8839 (Professional Claims)
BlueCard® (Out-of-Area Blue Cross and Blue Shield Members)	Eligibility & Membership Line	1-800-676-BLUE or 1-800-676-2583
	Claims Status	1-800-444-2726
Electronic Data Interchange (EDI) Claims Submission	Customer Service	1-800-470-9630
Medicaid	Health Care Professional/ Member Services	1-800-845-3604
Anthem Workers' Compensation (AWC)	AWC Customer Relations	1-866-700-2168

Provider Data Management

Provider Change Request: Provider Data Management (PDM) facilitates the data maintenance of Provider information for Medical Groups, Facilities, Physicians, Behavioral Health and Ancillary Network Providers.

- Email address: ProviderDatabaseAnthem@anthem.com
- Fax: 1-818-234-2836

! Provider Network Education and e-Solutions

The Provider Network Education team develops, delivers and supports quality educational programs for the staff of physicians, Hospitals, medical groups, ancillary and other health care professionals. We offer several tools that explain best practices and process improvement methodologies. These tools will help you, our health care Providers, concentrate on what is most important: the care of your patients and our Members. We offer a series of complimentary education and e-learning options: seminars, webinars, job aid library and self-paced, on-demand "e-courses." Constant changes within the health care industry demand rapid development of education, training solutions and tools that can be accessed through the Internet via your computer. Our e-learning tools are available 365/24/7 and designed to allow us to reach out to the geographic diversity of our statewide Provider community.

Complimentary Seminars

Come and enjoy a 'face-to-face' exchange of information between Anthem Blue Cross (Anthem) staff and your staff on a variety of topics. Our seminars are offered to Anthem contracted health care Providers at many locations throughout the state.

For locations and registration information, go to anthem.com/ca > select the **Providers** link at the bottom of the page then, under the *"Providers|Spotlight"* section select > Provider Network Education Seminars and Webinars.

Webinars

Webinars offer a 'live' interactive session conducted remotely via the Internet and facilitated by the Provider Network Education team and subject matter experts (SME). Our webinars are offered annually and there is also a "Listening Library" of our recorded webinar sessions for your convenience.

On-demand, e-Courses

On-demand, e-courses offer a self-paced instructional environment where you can select the topic of your choice and go as fast or as slow as you wish, all in the comfort of your office and at your computer.

Email Address
network.education@anthem.com

Quality Improvement Programs

The goals, objectives and structure of the Quality Improvement program are responsive to the changing needs of Members, Providers and the health care community.

For more information regarding our Quality Improvement Program

Additional information on Anthem's Quality Improvement programs can be found on anthem.com/ca, select the **Providers** link at the bottom of the page then, **Enter**. On the Provider Home page, under the "*Health & Wellness*" tab (on the blue toolbar) select Quality Improvement and Standards.

Regulatory and Accrediting Delegation Oversight

PMG Delegation Oversight, Including Credentialing and Utilization Management

Area/Contact	Telephone Number
Delegation Oversight Shonnie Cooper, Director	1-706-564-1555
Utilization Management Oversight Lynn Bricking	1-513-274-3066
Credentialing Oversight Nicole Dorcean	1-813-830-6900 ext. 77038

Stop Loss

Effective January 1, 2017, the Anthem Blue Cross' (Anthem) Hospital Stop Loss Customer Service number, 1-818-234-3603, will be discontinued. After this date, you will no longer be able to reach a person or leave a voice message.

Beginning January 1, 2017, all Facility stop loss inquiries should be directed to the number located on the back of the Member's ID card. If you do not have a copy of the Member's ID card, call toll-free 1-800-676-2583 and you will be transferred to the appropriate customer service department. As a reminder, from December 2016 through January 2017, a recorded message with these same instructions and any additional updates will be included when you call the current Hospital Stop Loss phone number at 1-818-234-3603.

For California contracting inquiries, email CAContractSupport@anthem.com, or visit anthem.com/ca > Providers > and select the "Contact Us" link located in the upper right-hand corner of the Home page.

Third Party Administrator (TPA)

For eligibility, Claims status and customer service, contact the TPA. For contractual allowances/Claim pricing contact Anthem at our dedicated Manage Care Service (MCS) phone line listed below or through our dedicated MCS Web Portal on Availity:

Anthem Blue Cross	
MCS Provider Services	1-800-688-3828
MCS Provider Services Web Portal	Availity.com and select MCS CA

Utilization Management (UM)

UM Intake	Telephone
Commercial HMO/PPO	1-800-274-7767 1-866-815-0839 (Fax)
Medicare HMO/PPO	1-866-797-9884
CalPERS membership only	1-800-451-6780 1-800-618-9410 (Fax)
Specialty Drug Pre-Service Medical Review Program	1-800-274-7767, option 4 1-866-408-7195 (Fax)

UM Intake	Telephone
Commercial HMO/PPO	1-800-274-7767 1-866-815-0839 (Fax)
Note: Drug list and the Prescription Drug Prior Authorization Request Form are located online at anthem.com/ca. When faxing requests, the Prescription Drug Prior Authorization Request Form is required. No other pre-service review request form will be accepted. Hours of Operation: 7:30 am to 5 pm PST	

UM for Federal Employee Program (FEP)

Refer to the subsection, *About the Blue Cross and Blue Shield Service Benefit Plan* in the *Federal Employee Health Benefits Program (FEHBP)* section in this Manual for UM contact information.

Website Address

The Anthem Blue Cross website is anthem.com/ca, select the Providers link at the bottom of the page; features behavioral health resources, pharmacy formulary information, medical policy, provider forms and much more. For Medicare Advantage information, visit anthem.com/ca/medicareprovider.

Workers' Compensation Services

Anthem Workers' Compensation (AWC) is an affiliate of Anthem Blue Cross. AWC focuses on integrating group health and Workers' Compensation. This approach allows employees and Members to use the same network for both occupational and non-occupational treatment. AWC currently provides network access to Other Payors (includes network as both a PPO and as a Medical Provider Network) for insurance companies and self-insured employers, Third-Party Administrators and Managed Care Companies for their clients in California. This includes both medical and behavioral health Providers as listed on the Workers' Compensation online Provider finder. A list of participating Other Payors is available in ProviderAccess® under the Network Leasing link.

Workers' Compensation educational articles and training materials are available on our website, anthemwc.com/home_provider.asp or, for more information, on AWC call 1-866-700-2168 toll free.

Availity Web Portal (Availity)

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Availity Web Portal (Availity) 2
AIM Specialty Health (AIM) 3

Introduction

The Availity Web Portal (Availity) is a secure website for Anthem Blue Cross (Anthem) eligibility, benefits and claim status inquiry functionality and more (see the important update below, where Availity will soon contain even more content). All Participating Providers must register for Availity to access these functions and additional 'value-add' features and services.

ProviderAccess® is Anthem's secure website that gives our contracted Providers access to Anthem proprietary information online.

! IMPORTANT UPDATE ON PROVIDERACCESS: Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality and content will move to Availity. This change does not affect the anthem.com/ca public website.

If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration in Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. No further registration is needed if you have already registered with Availity.

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth.

This section provides important facts and features about the secure website, Availity.

Availity Web Portal (Availity)

Availity is a leading health information network, providing business and clinical services and resources. This secure, multi-health plan portal is available at no charge to physicians and other health care Providers. Availity improves efficiencies through simplified and streamlined health plan administration. Availity is health information when and where you need it, and that benefits patients, Providers and health plans!

Availity minimizes time spent on the telephone with Customer Service and allows more time with patients. In fact, it may eliminate 80 percent of routine inquiries to Anthem.

This secure website is available 24 hours a day, seven days a week, except during scheduled maintenance and national holidays. They also offer printer-friendly format on all information screens.

Get the information you need instantly

You can access real-time eligibility and benefits, claims status information and much more through our secure website at availity.com. In addition, you can submit simple batch eligibility and benefit inquiries for multiple patients with multiple plans and receive a consolidated response in a consistent format.

- Member eligibility and benefits inquiry – includes local and out-of-state BlueCard® Members
- Claim status inquiry – includes local and out-of-state BlueCard® Members
- Secure messaging* – submit a question on a via a secured email to a Provider inquiry support team
- Referrals and Precertification – templates make it easy to enter clinical detail
- Patient Care Summary – real-time, consolidated view of a Member's medical history across multiple Providers

- Clinical messaging – clinical alerts on patients' care gaps and medication compliance indicators
- AIM Specialty Health℠ (AIM) – link to precertification requests and inquiries through AIM
- Member Certificate Booklet – view a local plan Member's certificate of coverage (EOC), when available

**The user must be registered with ProviderAccess for these roles.*

How do we get registered for Availity?

1. Go to availity.com. Select the link, Register.
2. Complete the online registration wizard.
3. You will receive an email from Availity with a temporary password and next steps.
4. If you need further assistance, call 1-800-282-4548 toll free for technical support.

Available training

Once registered as an Availity user, simply log in to the website and choose the Help tab from the top navigation bar, then the appropriate selection from the drop-down. Availity offers a variety of ongoing training options, including live and on-demand webinars, online demonstrations, local workshops, comprehensive help topics, tip sheets and more.

AIM Specialty Health (AIM)

AIM manages certain programs and services impacting Members in California. Refer to the *Medical Management Programs* section of this Manual for a complete description of the Radiology and Sleep Management Programs administered by AIM. Providers may access AIM thorough ProviderAccess. The following documents and activities are available on ProviderAccess.

The following represents some of the AIM information that can be found by selecting AIM's "Imaging Management Program," "OptiNet® Online Assessment," and "Specialty Drug Requests" under News & Information on the ProviderAccess home page.

- AIM FAQ
- Imaging and OptiNet Quick Reference Guide
- AIM CPT Code Lists
- Report Card
- OptiNet FAQ
- OptiNet Registration Check List
- Cardiology Preauthorization Notification Letter – November 22, 2010
- Cardiology CPT Code Preauthorization List
- Cardiac Services Program FAQ
- Clinical Information Worksheet (MPI/SE)
- Specialty Drug Requests Announcement Letter – August 4, 2010
- Specialty Drug Requests FAQ

There is also a link to AIM's "Radiation Patient Safety Program" under News & Information.

Submitting Requests for Advanced Diagnostic Imaging and Sleep Services

Select "Referrals & Pre-auths," then "Imaging and Specialty Drug Requests" to link to AIM.

Preauthorization

Requests can be submitted online via AIM's web-based application ProviderPortal℠. AIM's ProviderPortal is available 24 hours a day, seven days a week. It is fully interactive, processing preauthorization-service review requests in real time using proprietary clinical criteria. Once on the AIM's ProviderPortal, a tutorial "How To Request an Order" is available under "Reference Desk," then "Interactive/Tutorials."

Confirming Requests for Advanced Diagnostic Imaging and Sleep Services

Select "Referrals & Pre-auths," then "Imaging and Specialty Drug Requests" to link to AIM.

Once on the AIM's ProviderPortal, a tutorial "How To Check the Status of an Order" is available under "Reference Desk," then "Interactive/Tutorials."

AIM's Radiology and Sleep Management Programs, and OptiNet®

If you are a servicing Provider and have not completed your assessment online, log on to ProviderAccess, choose the "Referrals & Pre-auths" tab, select the link for "Imaging and Specialty Drug Requests" and then select the option called "Access Your OptiNet Registration," select the option in the green box, "Access Your OptiNet Registration," then select the option "Begin Registration" located in the lower corner of the pop-up page.

Once on AIM's ProviderPortal, a tutorial "How To Complete an OptiNet Registration" is available under "Reference Desk," then "Interactive/Tutorials."

If you have already completed your OptiNet Online assessment, you will be able to access your survey information, site score and cost information online, and update your information as appropriate. AIM will send periodic email reminders to the email address used to register the site in order to provide an **'alert'** that date-sensitive information is going to expire. Outdated and missing information could lead to a lower quality score, so the **'alert'** reminds you to keep your OptiNet registrations current and complete.

Eligibility

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Introduction

There are a wide variety of criteria used to determine who is eligible for benefits, as well as when a Members eligibility begins and terminates. The scope and complexity of these criteria make a listing of them infeasible for this Manual.

In addition, an overview of health care identification cards (HCID cards) is presented at the end of this section.

ProviderAccess® and the Availity Web Portal (Availity)

Availity replaced ProviderAccess' eligibility, benefit and claim status inquiry functions. To register, log on to availity.com.

IMPORTANT NOTE: All ProviderAccess functionality is transitioning to Availity as of January 20, 2017.

ProviderAccess and Availity are the exclusive web portals available, free of charge, to Providers. Availity enables health care Providers to check Member's benefits, eligibility and deductible status, and claims status online.

Through Availity, detailed information on an unlimited number of Members is available at health care professionals' convenience. Availity allows users to spend less time on the telephone and devote more time to other important tasks.

The information available on Availity is updated in real time and provides the same information health care Providers would obtain if they were to call customer service.

Specific information regarding how to check eligibility is available within the *Availity Web Portal (Availity)* section of this Manual.

Contacting a Customer Service Representative

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

Large Group Members	1-800-677-6669 (toll free)
Small Group Members	
Individual Members	1-800-333-0912 (toll free)
Federal Employee Program (FEP)	1-800-322-7319 (toll free)

Interactive Voice Response (IVR) Unit

IVR is an automated computer system that provides "real-time" information on the most current eligibility data for all Anthem non-Federal Employee Program (non-FEP Members).

To access the IVR, use the customer service phone number on the Member's HCID card.

The IVR is available from 1:30 am to 12:30 am PST.

The FEP IVR is available 24 hours a day, seven days a week. The toll-free phone number is 1-800-322-7319.

Be sure to have your tax identification number and the Member's nine-digit certificate number ready before dialing the IVR toll-free number. If you wish to have the information faxed back to you, have your 10-digit Fax number available, because you must enter your Fax number after the appropriate prompt.

As stated in the "Introduction," the IVR is not available for verifying BlueCard Program eligibility. Providers should call the BlueCard toll-free phone number 1-800-676-BLUE (2583) for assistance.

After a brief welcome message, the IVR will lead you through the appropriate steps to obtain eligibility information. (This does not apply to the FEP IVR.)

Note: When navigating through the IVR system, the following options can be used at any time:

- To return to the previous menu, press *6.
- To repeat the message, press *7.
- To return to the main menu, press *8.
- To speak to customer service, press 0.

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

Health Care Identification Cards (HCID Cards)

All Members are issued an HCID card. The Member should carry his or her HCID card at all times and present it when seeking medical services.

HCID cards provide the following information:

1. Member name
2. HCID number
3. Employer group number (for group coverage only)
4. Anthem plan code
5. Rx Bin
6. Rx PCN
7. Rx Group
8. Coverage(s)
9. Copays
10. Product name

11. ID card issue date
12. Medical group name, address and phone number (if HMO or POS)
13. Additional benefits rider (where applicable)
14. Claims mailing addresses and customer service telephone number(s) for the medical program and any supplemental benefits
15. Instructions regarding carrying and using the HCID card (information on carrier letter)
16. Telephone number for preauthorization or pre-service review (if PPO)

Refer to the *Exhibits* section for a few samples of HCID cards, or select one of the specific examples below:

- Blue Cross HMO
- Blue Cross Point of Service
- Blue Cross PPO
- Covered CA (Health Insurance Exchange)

All Anthem Members receive a unique identification number on their renewal date. The Anthem identification number is a nine-digit alphanumeric identifier, with a letter in the fourth position, except for client-assigned identification numbers, which will be multiple alphanumeric combinations. If you have any questions regarding the HCID cards, refer to the customer service telephone number on the Member's HCID card.

Customized Health Care Identification Cards (HCID Cards)

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

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

Mobile Health Care Identification Cards (HCID Cards)

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

Managed Care Services Pricing Services – Third Party Administrators

Managed Care Services (MCS) is the collaboration between Anthem and approved Third Party Administrators (TPA) to deliver access to the Anthem PPO network to self-funded clients. Eligibility for MCS

is handled at the TPA. All verification of eligibility, benefits and claims inquiries must go through the TPA. Refer to the back of the Member HCID card for the customer service numbers to call.

Joint Administrative Agreement – Third Party Administrators

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

BlueCard® Program

For information specific to the BlueCard Program see section *BlueCard* and the BlueCard Provider Manual online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.

Medicare Advantage

For information on Medicare Advantage refer to the *Medicare Advantage* section of this Manual.

Federal Employees Health Benefits Program

For information specific to Federal Employee Program (FEP) see section *Federal Employees Health Benefits Program* (FEHBP) of this Manual.

Finding a Behavioral Health Provider

To find a participating behavioral health Provider, the Member can call customer service at the toll-free telephone number on his or her HCID card. Members may also access the company's online directory at anthem.com/ca by selecting Menu in the top left corner, select Find a Doctor. Anthem has enhanced the *Find a Doctor (Provider Finder)* tool to allow Members to search for participating Providers using the speed and convenience of online technology.

The *Find a Doctor (Provider Finder)* rapidly drills down to the information a Member is seeking, and then generates a customized, printable mini directory. This directory may even be emailed from Anthem's website to a Member's email account.

Members may access fepblue.org to locate contracting Providers or contact customer service toll-free number at 1-800-322-7319.

An added behavioral health feature is the *Refine Search* function, which allows a Member to drill down their search. Members may search by matching available options to a behavioral health Provider.

Available options are:

- Select a Language, which refers to the languages the behavioral health Provider speaks.
- Gender, which refers to the gender of the behavioral health Provider.

- Accepting New Patients, which refers to whether the behavioral health Provider has appointment openings.
- Areas of Expertise, which refers to a behavioral health Provider's self-reported areas of expertise such as adjustment, anxiety, mood, etc.
- Provider Ethnicity, which refers to the ethnicity of the behavioral health Provider.

Anthem offers this technology in an effort to improve a Member's access to care.

Newborns

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

Newborns of eligible dependent children are not covered.

For HMO Members, if the newborn is discharged home with the mother, the parents may enroll their newborn with the PCP or medical group of their choosing. If the newborn remains in the Hospital after the mother's discharge, the newborn should be added to the same medical group as the mother, until discharged home (verify with HMO Plan if this applies to Member's policy). If the newborn remained in the Hospital after the mother was discharged, but the newborn is discharged and is now home, the newborn may be enrolled in a different medical group effective the date that the newborn was discharged from the Hospital. Pediatric office visits are subject to the same scheduled copayments as regular office visits.

Well Baby and Well Child care are Covered Services subject to any scheduled copayments.

Domestic Partners

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

If you have any questions regarding whether this coverage is applicable to a specific employer group, call the Provider Care department toll-free phone number 1-800-677-6669.

Admissions Process

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Introduction

This section provides inpatient information concerning Hospital admissions. An admission is one component of the Anthem Blue Cross (Anthem) Medical Management program that addresses the appropriate utilization of Hospital services.

Transplant Services: Centers of Medical Excellence (CME) for Transplant

Members requiring transplant services require special handling. Anthem HMO Transplant requests are coordinated through the Primary Medical Group (PMG) or Independent Practice Association (IPA). All transplant requests for benefits, evaluation, prior authorization and inpatient admissions should be referred to the PMG. All other Anthem Members are managed directly through the Anthem Transplant Case Management Department. The telephone number for the Anthem Transplant Case Management Department toll-free phone number is 1-888-574-7215. If the Member has the benefits and meets the medical policy, he or she will have access to an Anthem CME Facility.

The transplant Benefit Specialists provide the referring and treating physicians with information on the Anthem CME network, with the exception of the HMO Members. For HMO Members the network and benefit information will be provided to the PMG and the PMG will communicate and work with the Facility. If the Member has been directed to a non-Anthem CME, the referring physician is asked to redirect the patient to an Anthem CME. Also, medical information is gathered for medical review by the CME transplant case manager.

The Member and his or her family are then contacted by an Anthem transplant case manager, and care is coordinated throughout the treatment and transplant continuum.

If the Member is an Anthem HMO Member, the transplant department will re-direct the Facility to the PMG/IPA, to discuss using a network Hospital, perform prior authorization review of the transplant and inpatient review, and agree on how the Member's care will be handled.

Refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* in the *Exhibits* section of this Manual.

Anthem Blue Cross HMO

Anthem delegates emergency and nonemergency (elective) admissions within the PMG's/IPA's contracted service area along with Utilization Management (UM) activities to the PMG/IPA. PMGs/IPAs are responsible for authorizing, providing, or arranging for Covered Services and quality care to Members. The PMG's/IPA's *Medical Services Agreement* with Anthem requires that Members be admitted to participating Hospitals and Facilities.

Elective Inpatient

The pre-service review process begins with a request from the treating physician, physician's office staff, Hospital representative, or Member prior to the planned admission or service. If the service is requested via telephone, the Anthem Interactive Voice Response (IVR) prompts the caller to enter the subscriber's identification (ID) number. The IVR system routes the call to the appropriate UM department.

If the service requested by the Provider requires prior authorization, the intake representative obtains demographic information, establishes the case online and forwards the case to the clinical reviewer. A clinical review is conducted utilizing approved screening criteria and/or Anthem Medical Policy. When the admission or service meets criteria, the admission or service is approved. For inpatient admissions, an initial length of stay is assigned. If the admission or service does not meet criteria, refer to the physician review process later in this Manual.

When pre-service review is completed, the physician, Hospital, Facility or other health care professional(s), and the Member are notified verbally and/or in writing of the UM reference number, the specific services and dates approved as Medically Necessary.

For a complete overview of this process, refer to the *Medical Management Program* section of this Manual.

Non-elective (emergency) or Non-pre-certified

If an elective admission was not pre-certified or the admission was unplanned, the Facility must notify Anthem of the admission on the first business day following admission and provide relevant clinical information and level of care.

The clinical reviewer will assess the clinical information submitted for severity of illness, intensity of service and site of service; certifies the appropriate level of care when criteria are met. If the admission or service does not meet criteria, refer to the physician review process later in this Manual.

Continued Stay Review

Continued Stay review may occur by telephone, FAX, electronic communication or on-site clinical review.

Continued Stay review continues until the Member is discharged, or until inpatient care is no longer authorized. Continued Stay review will be conducted on all pre-certified admissions that exceed the initial pre-certified length of stay. The Facility is required to notify Anthem and submit relevant clinical information to support the extended length of stay request.

The clinical reviewer coordinates with the physician, Hospital, Facility, or other health care professional to address discharge planning and transition of care needs.

For a complete overview of this process, refer to the *Medical Management Program* section of this Manual.

BlueCard Program®

For information specific to the BlueCard Program see section *BlueCard* and the BlueCard Provider Manual, online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.

Federal Employees Health Benefits Program

For information specific to Federal Employee Program (FEP) see section *Federal Employees Health Benefits Program* (FEHBP) of this Manual.

Medicare Advantage

! In this version of the Manual, for information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook. Or, refer to the *Medicare Advantage* section of this Manual.

Claims Submission

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Introduction

This section provides general billing requirements. An overview of electronic and hard copy billing and contact information is also presented. The requirements are listed by product type with a detailed listing of billing requirements by service category contained at the end of the section. The most common situations that result in returned or rejected Claims and processing delays are identified.

Supplemental billing information is provided in dedicated sections of this Manual for the following Provider Agreements: Ambulatory Surgery Center, Dialysis Facility, Hospital-based Home Infusion Therapy (HIT), Home Health Agency, Hospice, Mental Health Facility, and Skilled Nursing Facility (SNF).

"Member" is used to reference a Covered Individual, Insured, and Covered Person.

Enrollee, Subscriber, eligible Dependent Spouse/Domestic Partner, Child or Contract Holder, and the meaning of each are synonymous with any such other.

Throughout this section we use the term "Total Eligible Billed Charges." This means the Facility's billed charges for Covered Services, except for those charges that are identified as disallowed charges in your Agreement with Anthem or in the Provider Manual. Disallowed charges are not eligible for reimbursement.

General Billing Requirements

The following are requirements for billing Anthem Blue Cross (Anthem). Billing requirements can be found in the appropriate service category in this section. Unless otherwise stated in your Agreement with Anthem, you are required to comply with these billing requirements. Transplant billing and coding guidelines can be found in the *Anthem Centers of Medical Excellence Transplant Network Contract Operations Manual* in the *Exhibits* section.

If you have any questions, call the Anthem Customer Service phone number on the Member's health care identification card (HCID card)

1. **! Billing requirements for inpatient and outpatient Claims.** To ensure the accurate and timely processing of electronic and hard copy inpatient and outpatient Claims, use the following requirements for the admission and discharge hour fields (fields 13 and 16 on the *UB-04 Claim* form):
   - **For inpatient Claims, include the actual admission and discharge hours, using a 24-hour clock (military time).** The only exception is for interim inpatient Claims, when the admission and discharge hour fields may be left blank. Do not insert "99" in those fields.
   - **For Hospital Outpatient Claims.** For Hospitals that have the midnight, 24-hour, or 48-hour rule in their Agreement with Anthem, include the admission and discharge hours instead of leaving the field blank. **Exception:** refer to your Agreement for other billing instructions, if applicable.
   - **For FEP, Outpatient Hospital Claims**, include the actual admission and discharge hours, using a 24-hour clock (military time). Contracts that contain the midnight/24-/48-hour rule should not leave these fields blank or insert "99." Populating these fields also assists in determining multiple, separate visits on the same day. **Exception**: refer to your Agreement for other billing instructions, if applicable.
2. **Billing requirements per Agreement.** Anthem's billing requirements apply to all of Anthem's Member's claims.

3. Applicable Anthem Rate. The Anthem Blue Cross (Anthem) Rate shall be the rate in effect as of the date of admission (inpatient claims) or date of service (outpatient claims) for all Covered Services not based on a DRG. For all Covered Services paid based on a DRG reimbursement, the Anthem Rate shall also be the DRG Rate in effect on the date of admission. The DRG Relative weights and groupings are based on the date of discharge.

4. CMS Hospital Acquired Conditions (HAC). Anthem follows CMS's current and future recognition of HACs. Current and valid POA Indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims. When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days that are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to Anthem for payment. In no event shall the charges or days associated with the HAC be billed to either Anthem or the Member.
5. Claims Submission Address. All Facility Claims, including Claims involving Other Payors as defined in your Facility contract, shall be submitted to the address set forth on the Member's HCID card. In addition, all Stop Loss Claims, including Stop Loss Claims involving Other Payors, must be submitted to the address set forth in the following section entitled "Stop Loss Billing Requirements."
6. Coordination of Benefits. Facility is required to inform Anthem, in writing (at the below addresses), within 30 days, upon discovery that a Member may have additional insurance coverage.

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

   For Federal Employee Members, submit to the following address:

   Anthem Blue Cross
   Federal Employee Program
   P.O. Box 105557
   Atlanta, GA 30348-5557
7. Emergency room and non-emergency Facility outpatient services leading to admission.
   - All inpatient rate(s) will include emergency and non-emergency Hospital outpatient services that are provided prior to an inpatient admission and are related to the condition for which the Member is admitted. Therefore, if a Member receives outpatient emergency services for an emergency condition, or other non-Emergency outpatient services, and is subsequently admitted as an inpatient, those outpatient emergency or non-emergency services are inclusive to the inpatient rate. The applicable inpatient Anthem Rate shall begin on the date that the Member is actually admitted as an inpatient. There is no separate payment for emergency or other outpatient services in addition to the inpatient rate.
   - Providers must provide admission and discharge time information when submitting bills for Facility-based charges.
8. FEP Never Events. The Never Events Policy requires all participating Providers to populate the Present on Admission (POA) indicator on all acute care inpatient Hospital Claims for all Never Events, as applicable; this does not permit participating acute care inpatient Hospitals to receive or retain reimbursement for inpatient services related to Never Events; and requires all participating acute inpatient Hospitals to hold Members harmless for any inpatient services related to Never Events.

9. **HCPCS codes.** Supply CPT-4/HCPCS codes for all laboratory, radiology, diagnostic, and infusion drugs for outpatient services and outpatient surgery on *UB-04 Claim* forms. Provide the CPT-4/HCPCS codes in form locator 44 of the *UB-04 Claim* form.
   - All CPT-4/HCPCS codes must be billed with the modifier component, when applicable.
10. **Itemization.** Services itemization is required when the "From" and "Through" service dates are different.
11. **Inpatient admission versus day of service.** An inpatient admission occurs when the patient is admitted as an inpatient to the Facility. An outpatient admission occurs when the patient is not admitted as an inpatient. A day of service, for the purpose of determining the number of days to be paid in accordance with the inpatient *per diem* reimbursement terms in your Agreement, occurs when the patient stays in any Facility accommodation past midnight or, depending upon the terms of your Agreement with Anthem, for more than 24/48 hours.

    Midnight/24- or 48-hour rule - Certain Facilities have an Agreement with Anthem that requires the application of the Midnight or 24-/48-hour rule to Members who are outpatients. If your Agreement contains one of those rules, subject to the five (5) exceptions below, the following applies – for all Members that occupy a bed as of midnight or, depending upon the terms of your Agreement with Anthem, for more than 24/48 hours, even if not admitted as an inpatient, the Anthem Rate will be the lesser of Facility's Eligible Billed Charges or the Inpatient General Acute Per Diem Rate as specified in your Agreement with Anthem. **[If your Agreement with Anthem does not include the Midnight or 24-/48-hour rule, then this specific paragraph and the remainder of this Section 11 below does not apply. In this circumstance, inpatient Claims will be paid in accordance with inpatient reimbursement rates and outpatient Claims will be paid in accordance with outpatient reimbursement rates regardless of how long the Member remains in the Facility as an outpatient.]**

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

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

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

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

    iv) Outpatient Infusion Therapy Services. Reimbursement will be the applicable Anthem Rate for outpatient infusion therapy services, until such time as Member is admitted as an inpatient or is

discharged from Facility, regardless of the duration of the Outpatient Service; and no matter where in the Facility the Member is discharged from.

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

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

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

12. Outpatient Surgery in the Emergency Department (Grouper 2 or higher). When outpatient emergency services and surgical operating room, recovery room, treatment room, or observation room Revenue Codes are reported and the surgical procedure is included in outpatient surgery grouper 2 or higher, and the surgical CPT code is billed on the same line as the surgical operating room, recovery room, treatment room, or observation room Revenue Code, the Anthem Rate for the applicable outpatient surgical grouper shall apply in lieu of the Anthem Rate for emergency services, but subject to the Midnight/24- or 48-hour rule included in your Agreement with Anthem. In all other circumstances, however, an emergency room visit that does not result in an inpatient admission shall be paid at the emergency services visit rate only; no matter how long the Member remains in the Facility and no matter where in the Facility the Member is discharged from.
13. Newborn "Well Baby" bill. A newborn Well Baby Claim should not be billed separately from the mother's Claim. All charges should be submitted on the same Claim. Routine Nursery is inclusive to the mother's charges.
14. Outpatient therapies. Outpatient therapy Claims require each therapy date rendered in order to correctly apply Member benefits.
15. Revenue codes. For Claims submitted on a *UB-04 Claim* form, revenue codes are required for all line items billed, whether sent on paper or electronically.
16. Split-year Claims. For services that begin before or during December of one year, but extend into or beyond January of the following year, split the Claims at the calendar year's end. This is necessary to accurately track calendar-year deductibles and copayment maximums.
17. System edits. Edits are in place for both electronic and paper Claims. Therefore, Claims not submitted in accordance with requirements cannot be readily processed and, most likely, will be returned.
18. Type of bill code. All Claims must have the appropriate type of bill code. The three-digit type of bill code provides the appropriate Facility type, billing classification and frequency information.
19. Utilization Management care levels. For Anthem HMO Claims that require Utilization Management designated care level (e.g., subacute care services), enter the approved care level in the Treatment Authorization Code-field, form locator 63 of the *UB-04 Claim* form.

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

Hospital Stop Loss Billing Instructions

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

Stop Loss Billing Requirements

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

- Billing Requirements – Anthem's Hospital Stop Loss billing requirements apply to all Anthem Member inpatient Claims submitted for payment under the Stop Loss provision of the Agreement.
  - Type of Bill Code – All Claims must have the appropriate Type of Bill Code. The three-digit type of bill code provides the appropriate Facility type, billing classification and frequency information. Note: Claims submitted with incorrect or inappropriate bill types will either delay the Stop Loss payment or result in an incorrect Stop Loss payment.
    - Type 111 – A completed Claim, from admit to discharge, should be coded as a Type 111.
    - Type 112 – Continuing interim Claims submitted to the Hospital Stop Loss Processing Unit, regardless of the Total Eligible Billed Charges, will be rejected for complete and final Claim. Only the per diem payment will be processed on Type 112 billing.
    - Type 114 – Final interim Claims submitted to the Hospital Stop Loss Processing Unit, regardless of the Total Eligible Billed Charges, will be rejected for complete and final Claims. Only the per diem payment will be processed on Type 114 billing.
    - Type 115 – Late charge only.
    - Type 117 – Revised/Replacement Claims: These Claims should be used when the Claim is revised, as opposed to submitting a revised Type 111 bill.
  - Status Codes – The Status Code of the Claim must indicate that the Member has been discharged or transferred (see *UB-04* Data Specification Manual formally known as *UB-04* Billing Guidelines Manual) to be eligible for the Stop Loss provision. If the Member is still hospitalized, the bill will be processed as an interim Claim, and will not be considered under the Hospital Stop Loss provision until the Member has been discharged and the complete and final Claim is submitted to Anthem Blue Cross at either of the addresses listed in the next subsection, "Where to Submit for Stop Loss Reimbursement."

- Itemized Bill – For a bill to be considered for Stop Loss reimbursement, it must include both the *UB-04 Claim* and an itemized statement for the Member's entire admission at the Facility.

Where to Submit for Stop Loss Reimbursement

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

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

OR

Anthem Blue Cross
Attn: Hospital Stop Loss Processing Unit
21555 Oxnard Street
Woodland Hills, CA 91367

! *Hospital Stop Loss Inquiry Customer Service Number Discontinued*

Effective January 1, 2017, the Anthem Hospital Stop Loss Customer Service number, 1-818-234-3603, will be discontinued. After this date, you will no longer be able to reach a person or leave a voice message on this line.

Beginning January 1, 2017, all institutional stop loss inquiries should be directed to the number located on the back of the Member's ID card. If you do not have a copy of the Member's ID card, call the toll-free phone number 1-800-676-2583 and you will be transferred to the appropriate customer service department. As a reminder, from December 2016 through January 2017, a recorded message with these same instructions and any additional updates will be included when you call the current Hospital stop loss phone number 1-818-234-3603.

For California contracting inquiries, email CAContractSupport@anthem.com, or visit anthem.com/ca > select Let's get started in the middle towards left side of page > Scroll to bottom of page > select Providers > and select the "Contact Us" link located in the upper right-hand corner of the Home page.

Stop Loss Claim Submission Filing Limits

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

If the Claim is submitted after the filing period, it is not eligible. The patient is not responsible for this amount. If a Hospital believes a rejected Hospital Stop Loss Claim was submitted within the filing deadline set forth in the Agreement, acceptable evidence of timely filing (in one of the forms described in this Manual) must be attached to the Anthem Hospital Stop Loss rejection letter or denial Explanation of

Benefits from the other carrier and should be submitted to Anthem in a timely manner for consideration. Do Not Resubmit A Copy Of The Original Bill.

Hospital Stop Loss Exclusions

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

Provider 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) • Late Discharge (0996) • Beauty Shop, Barber (0998) • Other Patient Convenience Items (0999)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0110 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279; 0360	Video Equipment Used in Operating Room
0270, 0271, 0272	Nasal Cannula; Foley stat lock; Blood Pressure cuffs; SCD Sleeves/Compression Sleeves; Ted hose; Pulse oximeter probes; Oral swabs/toothettes; Urine collection unit/ containers/urinals; Isolation supplies; Tapes; Band aids; Telfa; Dressing Sponge; Gauze Sponge; Tegaderm; Opsite; IV start kits and IV supplies: (tubing, extensions, angio-catheters, blood IV tubing); Specimen traps; Skin cleansers; Gloves; Pads sanitary; ID bracelets/ allergy bracelets; Adult diapers or briefs; Gowns; Drapes; Kits; Sterile towel packs; Specimen containers; Basins/basin sets; Skin staplers/removers; Sutures; Lap sponges/raytecs; Suction tubing/suction tips; Dressings: Telfa; band aid; tegaderm; opsite; kerlix; Tapes; Prep/prep trays; Masks; Shoe covers; Hoods; Tip suction Yankauer; Bonnets/Hats
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
0263	IV Infusion for therapy, prophylaxis (96365,96366); IV Infusion additional for therapy: IV Infusion concurrent for therapy (96368); IV Injection (96374, 96379)

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0229, 0270, 0410, 0413, 0419, 0760 – 0762, 0769	• Other Special Charges • Observation hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator • Respiratory assessment charges
0230, 0270 – 0273, 0300 – 0307, 0309, 0310, 0390 – 0392	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Operating Room (OR) or Post-anesthesia Care Unit (PACU)
0250 – 0259; 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions
0256	Experimental drugs

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0270, 0300 – 0307, 0309, 0380 – 0387, 0389, 0390-0392	Venipuncture (CPT Code 36415, 36416 or G0001) • Specimen collection • Draw fees • Phlebotomy • Heel stick • Blood storage and processing blood administration (Rev codes 0380, 0390-0392, 0399)
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0360, 0410, 0460	Supplies and Equipment • Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board • Instrument trays and/or Surgical Packs • IV pumps and PCA (Patient Controlled Analgesia) pumps • Isolation supplies • Blood Pressure Monitor • Beds • SCD Pumps • Cardiac Monitor • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Davinic Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (specifically, conscious/moderate sedation) • Nursing care • Monitoring • Intervention • Pre or Post evaluation and education • IV sedation and local anesthesia
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 blood count, arterial blood gas, clotting time, glucose, 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

* Subject to the Member's Benefit Agreement.

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0996	Late Discharge
0998	Beauty Shop, Barber
0999	Other Patient Convenience Items

Common Reasons for Rejected and Returned Stop Loss Claims

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

- Filing Limits
  The Hospital Stop Loss Claim-filing deadline is specified in your Agreement and is the number of calendar days after the patient was discharged. All Hospital Stop Loss Claims must be submitted to Anthem within that deadline. If not, the Stop Loss Claim will be rejected as untimely. This time limit also applies to late charges and corrected Claims.
- Unable to Identify Member:
  a) For Members of Other Blue Plans (BlueCard®): The main identifier for out-of-area Members is the alpha prefix. The three-character alpha prefix at the beginning of the Member's identification number is the key element used to identify and correctly route claims. The alpha prefix identifies the Blue Plan or National Account to which the member belongs. It is critical for confirming a patient's membership and coverage.
  a) For Federal Employees Program (FEP), the alpha prefix is omitted in addition to other numeric digits. The FEP ID number starts with an alpha "R" and is followed by eight numeric digits. Supply the nine-digit ID number for all FEP submissions.
  b) Members of Anthem affiliates using a California Hospital: The affiliate's name must be clearly indicated, along with the ID number of the Member.
- Total Eligible Billed Charges do not exceed Hospital Stop Loss Dollar Threshold – The Total Eligible Billed Charges may not meet the Hospital Stop Loss threshold, based on the Agreement's specifications. Refer to the list below:
  a) Total Eligible Billed Charges are below the dollar threshold amount; or
  b) Removal of noneligible or disallowed charges caused the Total Eligible Billed Charges to fall below the threshold; or
  c) Removal of non-covered day charges caused the Total Eligible Billed Charges to fall below the threshold; or
  d) Total Eligible Billed Charges are less than the per diem threshold.

- **Federal Employee Claims subject to OBRA pricing and Centers of Medical Excellence (CME) Rates** – The Hospital Stop Loss provision may not apply when other rates are applied to the bill. Check your specific Agreement for Stop Loss exclusions.
- **Utilization Management Approval** – Hospital Stop Loss is only payable for the days approved as Medically Necessary. If the stay is not approved, the bill will not have the Hospital Stop Loss provision applied. In addition, if a portion of the stay is not approved as Medically Necessary and the exclusion of the charges for the non-approved days brings the Total Eligible Billed Charges below the threshold, the bill is not eligible for Stop Loss reimbursement.
- **Anthem Blue Cross Not The Primary Payor** – Hospital Stop Loss provision is only applicable to Claims for which Anthem is the primary payor.

Researching a Stop Loss Claim

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

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

Was the Claim electronically submitted?

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

Anthem Blue Cross Attn: Hospital Stop Loss Processing Unit P.O. Box 60007 Los Angeles, California 90060-0007	OR	Anthem Blue Cross Attn: Hospital Stop Loss Processing Unit 21555 Oxnard Street Woodland Hills, CA 91367

Was the Claim eligible for the Hospital Stop Loss Provision?

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

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

Anthem Blue Cross
Attn: Hospital Stop Loss Processing Unit
21555 Oxnard Street
Woodland Hills, CA 91367

! *Hospital Stop Loss Inquiry Customer Service Number Discontinued*

Effective **January 1, 2017**, the Anthem Hospital Stop Loss Customer Service number, 1-818-234-3603, will be discontinued. After this date, you will no longer be able to reach a person or leave a voice message on this line.

Beginning January 1, 2017, all institutional stop loss inquiries should be directed to the number located on the

back of the Member's ID card. If you do not have a copy of the Member's ID card, call the toll-free phone number 1-800-676-2583 and you will be transferred to the appropriate customer service department. As a reminder, from December 2016 through January 2017, a recorded message with these same instructions and any additional updates will be included when you call the current Hospital stop loss phone number 1-818-234-3603.

For California contracting inquiries, email CAContractSupport@anthem.com, or visit anthem.com/ca > select **Let's get started** and scroll to the bottom of the page > select **Providers** > and select the "Contact Us" link located in the upper right-hand corner of the Home page.

Electronic Data Interchange (EDI)

EDI allows Providers and Facilities to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions, such as:

- 837 Health Care Claim Professional
- 837 Health Care Claim Institutional
- 835 Health Care Claim Payment/Remittance Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 276/277 Health Care Claim Status Request and Response
- 278 Health Care Services Review – Request for Review and Response

Anthem is Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant and a strong proponent of EDI transactions because they will significantly reduce administrative and operating costs, gain efficiency in processing time, and improve data quality. Under HIPAA, as EDI transactions gradually replace paper-based transactions, the risk of losing documents, encountering delays and paper chasing is minimized.

The EDI section of this Provider Manual includes information needed to begin and increase the transactions your office is submitting electronically. Visit our online resources to learn more about the services and electronic filing options mentioned in this guide.

Online EDI Resources & Contact Information

At Anthem, we've dedicated a website to share electronic information with you or your EDI vendors (clearinghouses, software vendors and billing agencies). Our website gives you pertinent and timely information, along with helpful tools to ease electronic transactions.

To access all EDI manuals, forms and communications listed below, go to anthem.com/edi.

Find detailed answers in the Anthem HIPAA Companion Guide. The HIPAA Companion Guide has the details on how to submit, receive and troubleshoot electronic transactions required by HIPAA.

Whether you submit directly to us or use a clearinghouse, software vendor or billing agency, the HIPAA Companion Guide and the HIPAA Implementation Guide are effective tools to help address your questions. The more you understand how we process electronic transactions, the better your experience with electronic transactions will be – even if you use an outside service.

What you'll find online:

- EDI registration information and forms

- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost-savings
- Online tools for submitting electronic *CMS-1500* Claims directly to us – at no charge to Providers
- Filing instructions for EDI submission of eligibility, benefit and Claim status inquiries
- Anthem HIPAA Companion Guide with complete information on submitting and receiving electronic transactions
- Anthem report descriptions
- List of clearinghouses, software vendors and billing agencies
- FAQs and answers about electronic transactions
- Information and links pertaining to HIPAA
- Contractual agreements with our trading partners

You will find answers to the most frequently asked questions about submission options, connectivity, troubleshooting tips, contact information and much more.

Contacting the EDI Solutions Help Desk

For more information about electronic Claims filing, electronic remittance advice, eligibility benefit inquiry, Claim status and other transactions, call the Anthem EDI Solutions Help Desk for details. Our Help Desk can address questions regarding connectivity, registration, testing and the implementation process.

Business hours: 8 am – 4:30 pm PST
Monday – Friday
Phone: 1-800-470-9630 (toll free)
Email: E-Solutions.Support@Anthem.com
Website/Live Chat: anthem.com/edi – Select California

Live Chat is an instant messaging service where EDI Solutions Help Desk specialists are available to answer questions from our customers.

Submitting & Receiving EDI Transactions

Visit our website at anthem.com/edi for enrollment, approved Anthem vendor listing or refer to our HIPAA Anthem Companion Guide for complete instructions on how to send and receive these and other transactions electronically.

Select EDI Submission Approach

The transactions associated with EDI submission are:

- 837 Health Care Claim: Professional
- 837 Health Care Claim: Institutional

Providers must manage their own unique set of marketplace requirements, operational needs and system capabilities. Two basic methods are available to generate EDI transactions:

- Direct submission by Provider
- Submission by clearinghouse or billing service

Direct Submission by Provider

Under the direct submission approach, the trading partner is the Provider. The Provider's internal programming staff or systems vendor modifies the computer system to meet the format and quality requirements of the ASCX12N HIPAA Implementation Guides and Anthem Companion Guide. The responsibility of operating the computer, modem, communications software, and data compression software also lies with the staff or vendor.

Submission by Clearinghouse or Billing Service

Under the submission by Clearinghouse or Billing Service approach the clearinghouse or billing service is the trading partner. Services are paid by the Provider for the EDI preparation, submission and/or practice management. The business relationship between the trading partner and office or Facility is held strictly between the two parties. Typically, the clearinghouse will help you configure the necessary computer equipment or billing software.

Troubleshooting Electronic Submissions

How do I know when to contact Anthem or my clearinghouse and/or vendor?

Direct Submitters: having technical difficulties, problems with reports or any other related issues pertaining to electronic transactions, (1) contact your designated customer support center and (2) if further directed to Anthem, contact the EDI Solutions Help Desk with reports, password resets or any other related issues for electronic transactions.

Clearinghouse or Vendor Submitters: having technical difficulties with electronic transactions contact your designated customer service support center.

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

Effective with HIPAA, Anthem has the capability to accept secondary/coordination of benefits (COB), electronically. One of the benefits of the electronic Claim format (837) required by HIPAA is its COB capability without using paper Claims or copies of Explanation of Benefits (EOBs).

Anthem encourages Providers to maximize their investment in electronic submission and contact your clearinghouse or vendor to help determine what, if any, changes are required and how to get started.

Visit our website at anthem.com/edi and refer to our HIPAA Anthem Companion Guide on how to file these and other transactions electronically.

Medicare Crossover Claims

For information specific to Medicare Crossover Claims refer to the *Medicare Crossover* section of this Manual.

EDI Reports Speed Account Reconciliation

Electronic transactions produce an immediate acknowledgement report from Anthem, a virtual receipt of your Claim. You will also receive a response report listing Claim detail and initial entry rejections, which can immediately be corrected and resubmitted.

Timely reporting lets you quickly correct errors so you can re-submit electronic transactions quickly – speeding account reconciliation. The two-stage process outlined below must be closely monitored. Implement ways to monitor submissions and reconcile errors with electronic transmissions during these stages. If you work with an EDI vendor, clearinghouse or billing agency, it's your responsibility to ensure reports are accurate, flexible, clear and easy to understand. Additionally, ensure your office staff gets appropriate training on report functions.

You can find Anthem report descriptions, along with formatting specifications, error listings and troubleshooting tips online at anthem.com/edi or in our Companion Guide.

Stage 1: EDI Reconciliation – Provider's Office/Facility to EDI Vendor

Stage 2: EDI Reconciliation – EDI Vendor to Payer

Report Basics

- Work reports each day, ensuring prompt handling of Claims
- Reconcile both Claim totals and dollars
- Correct Claims with errors and resubmit them electronically to provide an audit trail and to avoid payment delays
- Work with EDI vendors to ensure Anthem reports are available. Our reports are your receipt that Claims were either accepted for processing or rejected due to errors.
- If you use an EDI vendor, you should work with them directly if there are questions about data content, delivery timeframes, formatting or errors

Electronic Remittance Advice (ERA)

The transaction associated with ERA is:

- 835 Health Care Claim Payment/Remittance Advice

Anthem offers secure electronic delivery of remittance advices, which explain Claims in their final status. This is an added benefit to our electronic Claim submitters. If you are an electronic Claims submitter and currently receive paper remits, contact the EDI Solutions Help Desk today to enroll for electronic remits.

Reduce accounts receivable days and administrative expenses by taking advantage of automated posting options often available with an electronic remittance. The content on the Anthem remittance advice meets HIPAA requirements, containing nationally recognized HIPAA compliant remark codes used by Medicare and other payors like Anthem.

How to enroll for ERA

Download the ERA enrollment form from our website or refer to the 835 HIPAA Companion Guide for additional details.

If you use an EDI vendor and/or clearinghouse, contact their representative to discuss the electronic remittances. This will ensure that ERA enrollment procedures are followed appropriately with the vendor and with Anthem.

Electronic Funds Transfer (EFT)

Anthem offers EFT, a secure process for directly depositing payments into the Providers' bank accounts. To enroll for EFT, download the EFT request form from our website at anthem.com/edi. Submit the completed form along with the required banking information by FAX or mail using the instructions on the request form.

Changes after enrollment

It is very important that you notify us of any changes to your ERA request form both before and after enrollment. This includes any changes to your vendor, tax identification number (TIN), billing address or bank account. Complete the ERA Request form found on our website.

Contact Information	
Business Hours:	8 am – 4:30 pm PST
Website/Live Chat*	anthem.com/edi > Select State CA > Select the button at the top of the screen for Live Help

Contact Information	
Telephone Number:	1-800-470-9630 (toll free)
Email Address:	E-Solutions.Support@Anthem.com

ERA/EFT	Contact
Enrollment, Banking or Vendor Changes, File Delivery and Formatting	EDI Vendor EDI Solutions Specialist: Phone: 1-800-470-9630 (toll free) EDI Support Email: E-Solutions.Support@Anthem.com EDI Registrations Email: E-Solutions.Registrations@Anthem.com Website: anthem.com/edi

Electronic Remittance Advice	Contact
ERA – Claim adjudication, payment and remark codes EFT – Bank Posting, Payment Delivery/Amount Questions	EDI Solutions Helpdesk: 1-800-470-9630 (toll free)
Anthem Delivery Schedule, File Layout and Field Definition	Anthem Blue Cross HIPAA Companion Guide anthem.com/edi > Select State CA > documents HIPAA Companion Guide > 835 Payment Advice

Real Time Electronic Transactions

The real time transaction includes:

- 270/271 Health Care Eligibility Benefit Inquiry and Response, or
- 276/277 Health Care Claim Status Request and Response

Many health care organizations, including health care partners, payers, clearinghouses, software vendors and fiscal intermediaries offer electronic solutions as a fast, inexpensive and secure method of automating business processes.

- Allows Providers to perform online transactions
- Provides coverage verification before services are provided
- Includes detailed information for ALL Members, including Members of other Blue Plans (BlueCard)

Anthem has electronic solutions, giving Provider's access to the Member's insurance information before or at the time of service, using the system of their choice. Anthem is certified for Phase I and II of the Council for Affordable Quality HealthCare's (CAQH's) Committee on Operating Rules for Information Exchange (CORE).

Features

Eligibility benefit inquiry/response is a real time transaction that provides information on patient eligibility, coverage verification and Member liability (deductible, co-payment, and coinsurance).

Claim status request and response is also a real time transaction that indicates whether an electronic Claim has been paid, denied or in progress.

Health care services review request and response is a real time transaction used to advise Anthem of upcoming Hospital stays and referrals to specialist.

Getting Connected with EDI Batch or Real Time Inquires

- Clearinghouses and EDI vendors often have easy-to-use web and automated solutions to verify information for multiple payers simultaneously through one portal in a consistent format.
- Contact your EDI software vendor or clearinghouse to learn more about options available.
- For connectivity options and file specifications, our HIPAA Companion Guide is available at www.anthem.com/edi

Getting Connected With Electronic Attachments

Anthem accepts Claims attachments electronically such as medical records, admission summaries, physician orders, diagnostic reports, radiology films and other types of Claims attachments. A vendor provides the ability to scan and send the images for processing. To take advantage of electronic attachments when filing electronic Claims to Anthem, contact Vyne Medical toll-free phone number 1-888-329-9988, option 2.

Hard Copy Billing

Institutions that are not set up to process Claims electronically are required to submit all hard copy Claims on the *UB-04 Claim* form (with scannable "red dropout ink"). All applicable data element blocks must be complete. If the form is incomplete, it is returned for the additional information needed for processing.

The consolidated address for Anthem Blue Cross Claims and Claims-related correspondence, except for FEP, Pharmacy, Dental and TPA Professional, is:

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

For FEP:

Anthem Blue Cross
Federal Employee Program
P.O. Box 105557
Atlanta, GA 30348-5557

For information specific to Federal Employee Program (FEP) see section *Federal Employees Health Benefits Program* of this Manual.

Tips for Clean Paper Claim Submission

! Tracer Claim. To avoid a Claim being rejected as a duplicate, make sure the Claim has not been previously received and denied, or rejected for missing information, by first checking the status of Claims through the Availity Web Portal (Availity). Availity provides the opportunity to "ask a question" about a online. You can send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is a feature accessed at www.availity.com

Secure Messaging should be used when you need to:

a. Inquire on the status of a claim
b. Have a billing/claim reimbursement question
c. Need to submit proof of timely filing
d. Request for retraction related to Third Party Liability or Worker's Compensation
e. Ask why the claim was processed incorrectly; provide reasons

For more information on secure messaging refer to the subsection *Secure Messaging – Availity* in this section and the section *Availity Web Portal (Availity)*.

Note: Billing/claim reimbursement questions can be submitted electronically through Claims Inquiry and Secure messaging accessible on Availity for Anthem, BlueCard out-of-area, and FEP (Federal Employee Program) Member claims.

! Illegible Claim forms or data. To ensure readable image quality, refer to the list below:

- Avoid submission of dot-matrix printed documents and lightly printed or carbon form.

- Stamp or write messages in the appropriate fields in blue or black ink, rather than red, because image scanning filters out red ink on documents.
- Use the "Remarks" field on Claim forms for messages.
- Do not stamp or write over boxes on the Claim form.
- Avoid stamping messages regarding regulatory filing requirements or timely filing limits – doing so can interfere with the ability to produce a Claim that is clean and can be processed.
- Use the "Remarks" field to stamp or write "Tracer" or "Past Due" on the Claim.

Submitting Claims

Corrected Claims/Late Charges

There are reasons that it may be necessary to submit a corrected Claim. For example, (1) corrected charges for the same date(s) of service may need to be added to the original Claim, (2) codes may need to be added or corrected, or (3) modifiers may need to be added or corrected. Corrected Claims must be stamped "corrected Claims" using black or blue ink and clearly identify the corrected information. Do not use a highlighter marker. The bill type code must also reflect that the Claim contains corrected or late charges through the use of the number "7" in the third position in the type of bill code. If, and only if, Facility's original Claim was submitted within the Claim filing limit set forth in your Agreement with Anthem, a corrected Claim may be submitted to Anthem no later than 365 days after the date of: (a) Anthem's first adjudication of the original Claim submission or (b) the date of Anthem's first request for information in response to the submission of the original Claim, whichever occurred first.

Anthem HMO

Claims for the following services for Anthem HMO Members should be billed directly to Anthem: Facility charges for inpatient Hospital services, outpatient Hospital services and outpatient surgery. With the exception of Out-of-Area emergency services described below, authorization for services from the HMO group should be submitted with the Claim.

- When submitting hard copy *UB-04 Claims*, attach the authorization and send to our consolidated mailing address:

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

Out-of-area Emergency Services: HMO groups are not required to authorize out-of-area emergency services, which are defined as emergency services rendered to Members at a distance of more than a 20-air mile radius from the medical offices of the HMO group or the satellite Facility to which the Member is assigned. When a medical group is organized as an independent practice association (IPA), out-of-area emergency services are those emergency services that are rendered to a Member at a distance of more than a 20-air mile radius from the nearest IPA-affiliated Hospital designated in the *Anthem Blue Cross HMO Medical Services Agreement*, *Exhibit B*, as the service-area Hospital.

Out-of-area emergency services also include out-of-area urgent care services, which are defined in the *Anthem Blue Cross HMO Medical Services Agreement* as "services needed to prevent serious deterioration

of a Member's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the Member returns to the service area."

The following guidelines apply to out-of-area emergency services:

- Medical groups must not authorize out-of-area emergencies.
- Members who are admitted to a Hospital out of their service area must contact Anthem Utilization Management within 48 hours of admission, unless extraordinary circumstances prevent such notification.

Note: Some HMO PMGs/IPAs require Hospital Claims be sent to them for review to determine authorization. The HMO PMG/IPA will then forward the Claim to Anthem Blue Cross. Check the requirements of the PMG/IPA before submitting a Claim.

Claims for the following services for Blue Cross HMO and Blue Cross Senior Secure should be sent directly to the Member's assigned PMG/IPA for processing:

1. Professional charges for in-area emergency room services
2. Any other Hospital-based physician professional charge

Anthem Point of Service (POS)

Submit all Blue Cross POS Claims to the address on the back of the Member's HCID card.

If medical services are not authorized by the Member's medical group, the Facility should indicate that the Member is using his or her PPO benefits by writing "Opt Out" in the remarks field on the Claim form. Do not put "Opt Out" in the authorization field, the system will process the Claim as a Medical Group Claim and reject as Medical Group liability.

Anthem PPO

Utilization review decisions are used solely to determine medical necessity, and the Facility's appropriateness and level of care. Utilization review certification does not guarantee Claim payment. The responsibility for Claim processing and payment determination rests only with Anthem.

PPO Claims can be sent by submitting a *UB-04 Claim* form. Paper Claims should be mailed to:

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

For Federal Employee Members, submit to the following address:

Anthem Blue Cross
Federal Employee Program
P.O. Box 105557
Atlanta, GA 30348-5557

Information specific to Federal Employee Program (FEP) refer to the *Federal Employees Health Benefits Program* section of this Manual.

BlueCard® Program

For information specific to the BlueCard Program see section *BlueCard* and the BlueCard Provider Manual, online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.

Claim Submission Filing Limit

Facilities must submit claims to Anthem within a specified amount of time (based on contracted limits) from the date of service (outpatient claims) or date of discharge (inpatient claims). For Claims that involve coordinating benefits with another carrier or Medicare, the date of the other carrier's *Explanation of Benefits* (EOB) or Medicare's EOB is used for determining the eligible submission period. The Medicare EOMB or the other carrier's EOB must be submitted to Anthem.

Refer to the *Exhibits* section for more information about what is acceptable proof of timely filing (*Timely Filing Acceptable Forms of Proof*).

Claims that are filed beyond the timely filing period will be denied accordingly. The patient is not responsible for this amount. If it is believed that the Claim was filed within the contracted timely filing guidelines, evidence of timely filing attached to the Anthem mail-back or denial EOB should be submitted in a timely manner for consideration. Do not resubmit the original claim. The following may be considered as evidence of timely filing:

Electronic

- Clearinghouse report demonstrating submission of claim to Anthem EDI Gateway within timely filing limit
- Level 2 Status Reports generated by Anthem EDI Gateway demonstrating submission of claim by Facility or acceptance of claim by Anthem within timely filing limit
- Dated request for additional information from Anthem (mail-back)
- Claim denial letter, RA or EOB from Anthem
- For EDI Claims that could not be processed by Anthem, a batch number or error report demonstrating that the claim was timely submitted to Anthem

Hard Copy

- Computer-generated Claim transaction history with the Anthem name from a billing system, together with proof of follow-up attempts made consistently and within a reasonable period of time
- Dated request for additional information from Anthem (mail-back)
- Claim denial letter, RA or EOB from Anthem
- Denial letter from other insurance carrier, dated and printed on letterhead
- Dated RA or EOB from other insurance carrier
- Proof of Member billing

Anthem reserves the right to determine whether the information supplied is acceptable for timely filing purposes.

Claim Payment Timeliness

When a Facility submits clean Claims to Anthem, the Hospital generally is paid within 30 working days for PPO Claims, and 45 working days for HMO Claims. Under no circumstances can Anthem Members be expected to pay the Facility any portion of money that is due from Anthem. To reduce payment confusion, the Facility should always verify the Member's eligibility prior to providing services. For more information, see the *Eligibility* section.

! Information for Contracted Providers – Claims Settlement Practices

The California Department of Managed Health Care (DMHC) has set forth regulation establishing certain Claim settlement practices and the process for resolving Provider disputes for managed care products. To the extent required by the DMHC, the Knox-Keene Act or accompanying regulations, the following is intended to inform you of your rights, responsibilities and related procedures, as they relate to Claim settlement practices for commercial HMO, POS and, where applicable, PPO products where Anthem is delegated to perform Claims payment. Unless otherwise provided herein, capitalized terms have the same meaning as set forth in *Sections 1300.71 and 1300.71.38* of *Title 28 of the California Code of Regulations*.

Claim Submission Instructions

1. Sending Claims to Anthem Blue Cross. Send all hard copies except for FEP, Dental, Pharmacy and Third Party Administrator professional Claims to:

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

   For FEP, send Claims to:

   Anthem Blue Cross
   Federal Employee Program
   P.O. Box 105557
   Atlanta, GA 30348-5557

2. Calling Anthem Blue Cross regarding Claims. See the *Directory of Services* section for a detailed listing of telephone numbers for Claims and Customer Service.
3. Claim submission requirements. Supporting information and documentation required by Anthem may be found in the various Anthem Providers Manuals.
4. Claim receipt verification. Claim status inquiry is available through Availity. Login to availity.com, select Claims tab and then Claims Status Inquiry from the drop-down menu. If your have a question about a claim, we offer an easy option. Refer to the Secure Messaging subsection mentioned below in this section of the Manual.

Claim Overpayments

1. Notice of overpayment of a Claim. If Anthem determines that it has overpaid a Claim, Anthem will notify the Provider, in writing, through a separate notice identifying the Claim, the name of

the patient, the date of service(s), and a clear explanation of the basis on which Anthem believes the amount paid on the Claim was in excess of the amount due (including interest and penalties on the Claim).

2. Contested notice. If the Provider contests Anthem's notice of overpayment of a Claim, the Provider must contact Cost Containment within 45 calendar days of receipt of the notice of overpayment of a Claim.
3. No contest. If the Provider does not contest Anthem's notice of overpayment of a Claim, the Provider must reimburse Anthem within 45 calendar days of the Provider's receipt of the notice of Claim overpayment.
4. Offsets to payments. If the Provider does not reimburse Anthem within 45 calendar days of the notice of overpayment of a Claim, then, Anthem shall offset an uncontested notice of overpayment of a Claim from the Provider's current Claim submissions. Anthem may only offset an uncontested notice of overpayment of a Claim against the Provider's current Claim submission when: (i) the Provider fails to reimburse Anthem within the timeframe set forth in the notice of overpayment described above; and (ii) Provider doesn't contest the overpayment.

Overpayment Recovery Procedure

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

The procedure for overpayment recovery is set forth below:

1. Day 1: Anthem identifies overpayment.
2. Day 3: Overpayment recovery letter is sent to the Provider
   - If the Provider believes that the overpayment was created in error, the Provider should contact Anthem in writing pursuant to the instruction in the overpayment letter.
   - If Anthem does not hear from the Provider or receive payment within 45 days, the following action is taken:
3. Day 45: Anthem will deduct overpayment amounts from future Claim payments.
4. Day 120: If a check for the overpayment has not been received or Anthem has been unable to recover the overpayment amount or Facility has not contested the overpayment amount, Facility is referred to a collection service.

Note: These are calendar days, not business days.

If you have any questions regarding overpayment recovery, refer to the *Directory of Services* for the appropriate telephone number for Cost Containment under "Overpayment Recovery Procedures."

! If you have been overpaid and wish to return the payment:

For overpayments for local plan Members and Members of other Blue Plans (BlueCard all alpha prefixes other than R followed by eight numeric digits), send the payment and all supporting documentation to the address listed below:

Overpayment Recovery
P.O. Box 92420
Cleveland, OH 44193

For overpayments for Members of private and public exchange plans send the payment to the following addresses:

Requested Overpayments	Voluntary Overpayments (Facility identified overpayment)
Anthem Blue Cross P.O. Box 5281 Carol Stream, IL 60197	Anthem Blue Cross CCOA Lockbox 73651 Cleveland, OH 44193

Supporting Documentation includes:

- All documents supporting the overpayment including EOBs from Anthem and other carriers, as appropriate
- Member ID number
- Member name
- Claim number
- Date of service
- Duplicate Payment Information
- Corrected Claims or Billing
- Reason for the refund

For questions, contact overpayment customer service at 1-818-234-3289. You may also request that we recover the overpayment on an upcoming remittance. Include a copy of the refund request letter if one had been sent to you, when sending your refund.

Balance Billing Prohibition

Except for applicable copayments and deductibles, a Facility shall not invoice or balance bill an Anthem Member for the difference between the Facility's billed charges and the reimbursement paid by Anthem for any covered benefit.

Common Reasons for Rejected and Returned Claims

Many of the Claims returned for further information result from common billing errors. The following is a list of some of the more typical situations:

1. Alpha prefix on subscriber ID not provided. The three-letter alpha prefix is critical for properly identifying and routing all BlueCard Claims for Members of other Blue Plans.
2. Date of injury not provided. When charges represent an injury diagnosis, provide a date of injury by completing the *UB-04* Occurrence Code, form locators 31 through 34. Correct coding of the Claim will allow the correct level of benefits to be applied to the Claim.
3. Duplicate Claims. Overlapping service dates for the same service(s) create a questionable duplicate Claim.
    - Duplicate Claims are sent before 30 days have passed (since last bill).

4. **Hospital Medicare ID number, Tax ID number and/or NPI not supplied.** On the *UB-04 Claim* form, enter the Medicare ID number in form locator 51, Tax ID number in form locator 5 and the NPI number in form locator 56.
5. **ICD-10-CM codes denied.** Claims that are coded with a preliminary, rather than a definitive, diagnosis will be mailed back for the definitive diagnosis.
6. **Filing limits.** The Claim filing limit is the time period after services are rendered that a Member or Provider has to submit a Claim for reimbursement. The time limits allowed to file a Claim are defined in your Provider Agreement.
7. **Insufficient or Incomplete Utilization Management information.** Ensure that the Utilization Management number is included, as required, on the Claim and that the approved services match the filed services.
8. **Member ID number is incomplete.** Specifically in the case of FEP, the alpha prefix is omitted in addition to other numeric digits. The FEP ID number starts with an alpha "R" and is followed by eight numeric digits. Supply the nine-digit ID number for all FEP submissions.
9. **Missing Health Care Common Procedure Coding System.** (Coding including, but not limited to, ICD-10-CM code, CPT/HCPCS, Revenue Codes and/or Modifier Codes.)
10. **Non-Member Donor Claims.** Use the *Non-Member Transplant Form* when submitting non-Member donor Claims. Check the box referenced under reconsideration of a returned and/or rejected Claim. Attach the Claim to this form and mail to Anthem. This will help expedite the processing.
11. **Nursing care.** Nursing charges are included in the Facility room-and-board charge and the outpatient-care charge. Nursing charges that are billed separately are considered unbundled charges and are not payable. In addition, Anthem will not pay Claims using different room rates for the same type of room to adjust for nursing care.
12. **Request for medical records.** When returning records to Anthem, it is imperative that the records be attached to the original mail-back form and returned. Do not reattach a new Claim copy. Do not combine other mail-backs in the same envelope, since it is likely that the records will not arrive in the correct department.
13. **Unlisted HCPCS codes submitted without description.** On the *UB-04 Claim* form, provide the description in form locator 43.
14. **Unreasonable numbers submitted.** Unreasonable numbers (e.g., 9999) are used, in the "Service Units" field.
15. **Unlisted Procedure or Service.** There may be services or procedures performed by physicians that are not found in Physician's Current Procedural Terminology (CPT); therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, Anthem needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.
16. **Admit and discharge hours on Inpatient and Outpatient Facility Claims.** On the *UB-04 Claim* form, provide this information in form locators 13 and 16.
17. **HCPCS and CPT Codes.** Current *HCPCS* and *CPT* manuals must be used because many changes are made to these codes quarterly, or annually, by the designated code set owner. These manuals may be purchased at any technical book store, or by:

Calling	Writing
The Practice Management Information Corporation (PMIC) 1-800-633-7467 (toll free)	Mail Orders American Medical Association Attention: Order Processing P.O. Box 930876 Atlanta, GA 31193-0876
The American Medical Association 1-800-621-8335 (toll free)	

! *Secure Messaging – Availity*

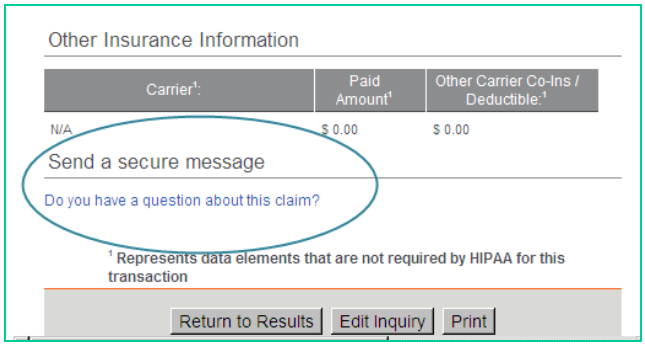
The Availity Web Portal provides the opportunity to "ask a question" about a claim online. You can send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is a feature accessed at www.availity.com. This functionality is only available on the Availity Web Portal. Secure messages can be sent for local Anthem, Anthem Blue Cross Blue Shield, BlueCard® out-of-area, and FEP (Federal Employee Program) Member claims.

Note: If you received a bar-coded mail-back letter regarding a claim, do not use Secure messaging to respond. Instead place the mail-back letter on top of the requested information and follow mailing instructions.

How do I send a Secure Message?

To send a secure message:

- Select the link "Do you have a question about this claim?"



Note: This option will only appear if your organization's Administrator has set up your account to include Secure Messaging.

- Once this link is selected, a new window will open and you will choose one of the seven questions from a dropdown box and use the free-form text box to add any detailed additional information related to your question and Select "submit." You will receive an Inquiry Control Number (ICN), which confirms your Secure Message has been sent and received.

How are Secure Messages processed?

- Your secure message is routed to Anthem Customer Service departments for a response through the secure messaging system, eliminating the need for you to make a phone call for the same information.
- If you have additional questions on a claim based on the response, you can reply to Customer Service's response with further questions.
- Messages are stored *within* the Secure Messaging tool, accessed under the Claims menu option on the Availity Web Portal, in the Inbox and Outbox. You can review messages you previously sent, view new responses received, and save messages to your computer or print for your records.
- Secure Messages are housed within a self-contained, secure email system, separate from your office email account. The messages are sent and received using your login credentials for the Availity Web Portal.

Secure Messaging should be used when you need to:

a. Inquire on the status of a claim
b. Have a billing/claim reimbursement question
c. Need to submit proof of timely filing
d. Request for retraction related to Third Party Liability or Worker's Compensation
e. Ask why the claim was processed incorrectly; provide reasons

For more information refer to the section *Availity Web Portal (Availity*) of this Manual.

Billing Instructions and Requirements by Service Category for Hospital/Facility

The following service categories represent a consolidated list of services rendered by the Facility. For each service category, Anthem requires mandatory billing codes in specific form locators. Providing the appropriate coding information results in speedy Claims processing and payment.

1. Inpatient acute care
2. Maternity and boarder baby care
3. Inpatient subacute care
4. Psychiatric inpatient services
5. Chemical dependency inpatient services
6. Psychiatric outpatient/residential services
7. Chemical dependency outpatient/residential services
8. Outpatient surgical services
9. Emergency room visits
10. Urgent care visits
11. Outpatient laboratory, radiology and diagnostic services
12. Outpatient therapies (physical, speech, occupational and respiratory)
13. Outpatient infusion therapy visit and pharmaceuticals

14. Hospice care
15. Sub-acute care
16. Hospitality day
17. Other services

The remainder of this section provides billing requirements applicable to each service category listed above.

1. Inpatient Acute Care

The billing requirements for inpatient acute care apply to each approved and Medically Necessary service day in a licensed bed (not covered under another category in this section) and include, but are not limited to, room and board (which includes all nursing care), professional services provided or arranged by Facility, emergency room services (if connected to the admission), urgent services (if connected to the admission), surgery and recovery suites, equipment, implantable devices, supplies, laboratory, radiology, imaging services, pharmaceuticals, observation services, telemetry, blood and blood product administration, non-physician professional services, and all other services incidental to the admission.

Billing instructions and requirements:

1. Utilization Management approval is required for all admissions.

2. Maternity and Boarder Baby Care

The billing requirements for maternity care apply to all live- and still-birth deliveries, and include payment for all associated services, including, but not limited to, all deliveries, including all vaginal deliveries and cesarean sections, and is applicable to both live births and still births, and includes payment for all associated services, including, but not limited to, room and board for mother (which includes all nursing care), nursery for baby (which includes all nursing care and non-physician professional services), delivery room/labor room/surgery suite, recovery suites, equipment, supplies, laboratory, radiology, imaging services, pharmaceuticals, observation services, and other services incidental to the admission.

The maternity rate does not apply to newborns who are admitted to an intensive care unit (ICU) or who remain in the Hospital as boarder babies after the mother is discharged. Therapeutic abortions are excluded for payment under this rate, as well as treatment for ectopic and molar pregnancies, and/or similar conditions. The maternity care rate covers the entire admission, except for admissions that are approved for extension beyond what is contractually indicated on the continuous inpatient days. In such cases, the inpatient acute care requirements will apply for each approved and Medically Necessary service day for the entire admission. For more information, refer to the Agreement.

Special notations to the above:

The Newborns' and Mothers' Health Protection Act of 1996 (the Newborns' Act), requires plans that offer maternity coverage to pay for at least a 48-hour Hospital stay following childbirth (96-hour stay in the case of a cesarean section).

An ante partum day beyond the 48-hour stay and the 96-hour stay is considered Medically Necessary under the following two conditions:

1. The Member is admitted one day and doesn't deliver until the following day

2. The delivery (complicated, normal vaginal delivery OR cesarean section) occurs after 6pm

In both of these situations, the ante partum day can be processed without obtaining medical records when the Hospital is a participating Facility, the negotiated rate is per diem, or the Hospital is non-participating. The time of the delivery must be included on the Claim. Reimbursement for the additional day(s) does not apply to participating Hospitals that have a global rate negotiated for the entire maternity stay. Note: for FEP, concurrent review must be requested for any stay over 48 hours for a vaginal delivery, or 96 hours for a C-section.

The boarder baby requirements are specific only to the days that the baby remains in the Hospital nursery after the mother is discharged, but do not apply to accommodations in the neonatal intensive care unit (NICU).

Prior authorization is required for this extended boarder baby service period. A separate Claim must be submitted for the period after the mother is discharged.

Billing instructions and requirements:

1. Utilization Management approval is required for all admissions.
2. ICD-10-CM procedure codes must be included for the delivery in form locators 74 (a, b, c, d). Applicable maternity procedure codes are 0Q820ZZ-0Q834ZZ, 0U7C7ZZ, 0W8NXZZ, 10A00ZZ-10A04ZZ, 10A07ZZ-10D07Z8, 10E0XZZ, 10J07ZZ, 10S0XZZ-10S07ZZ, 10T20ZZ-10T24ZZ, 10900ZC, 10903ZC, 10904ZC, 10907ZA, 10907ZC, 10908ZA, 10908ZC, 3E0DXGC, 3E0P7GC, 3E030VJ, 3E033VJ, 3E040VJ, 3E043VJ, 3E050VJ, 3E053VJ, 3E060VJ, 3E063VJ, 0UQC0ZZ-0UQC8ZZ, 0UQ90ZZ-0UQ98ZZ, 0DQP0ZZ-0DQP8ZZ, 0DQR0ZZ-0DQR4ZZ, 0TQB0ZZ-0TQB8ZZ, 0TQDXZZ-0TQD8ZZ, and 0TQD7ZZ, 0UQGXZZ-0UQG8ZZ, 0UQMXZZ-0UQM0ZZ, 0WQNXZZ. Applicable boarder baby revenue codes are 0170, 0171 and 0179, unless otherwise indicated. For more information, refer to the Agreement.

3. Inpatient Subacute Care

The billing requirements for inpatient subacute care include each approved and Medically Necessary service day in a duly licensed and accredited Facility, at the appropriate level of care. Each inpatient subacute care admission is considered a separate admission from any preceding or subsequent acute care admission and should be billed separately. Covered Services rendered during an admission include, but are not limited to, room and board (which includes all nursing care and non-physician professional services), recovery suites, equipment use, supplies, laboratory, radiology, imaging services, pharmaceuticals, observation services, and other services incidental to the admission. Subacute care includes levels of inpatient care less intensive than those required in an inpatient acute care setting.

All admissions and levels of care require prior approval. FEP benefits do not cover care rendered in a subacute setting unless approved through FEP Case Management. All subacute care admissions must be accompanied by a treatment plan that includes:

- Functional, reasonable, objective and measurable goals within a predictable timeframe for each skilled discipline
- A discharge plan and options that are individually customized and identified from the admission date, and that are carried forward from the admission date
- Weekly summaries for each discipline; required biweekly team conference reports

Defining Levels of Care

Level 1

Level 1 represents the most basic level of care (room and board, nursing care, ancillary services, supplies, medication, equipment, etc.) required by a patient who does not need general acute care, as provided in an inpatient acute care setting, but who requires documented, continuous skilled nursing care. Care must be Medically Necessary and the services must be authorized.

Billing instructions and requirements:

1. Utilization Management approval is required for admission.
2. A revenue code must be included for the approved subacute care level. The appropriate revenue code for Level 1 is 0191.

Level 2

To meet Level 2 requirements, in addition to meeting all requirements for Level 1, the patient must need one or more of the following services:

1. Wound care
2. Inhalation therapy by a licensed respiratory therapist, consisting of four or more treatments per day for skilled therapeutic intervention, which is not routine or a self-administered treatment, or self-administered pharmaceuticals
3. Rehabilitation services rendered by a registered occupational, speech and/or physical therapist for a documented rehabilitation diagnosis, including occupational, speech, or physical therapy lasting between 90 minutes and three hours per day, for five or more days per week
4. Initiation of nasogastric, gastrostomy and jejunostomy feedings, and administration of continuous feeding when Medically Necessary; total parenteral nutrition (TPN)
5. Continuous IV therapy via a peripheral or central line (other than solely for hydration), or via Heparin lock
6. Colony-stimulating factors
7. Ostomy care
8. Tracheostomy care
9. Special beds (e.g., KinAir, Clinetron)
10. Continuous passive motion machines
11. TENS/MENS units

Billing instructions and requirements:

1. Utilization Management approval is required for admission.
2. A revenue code must be included for the approved subacute care level. The appropriate revenue code for Level 2 is 0192.

Level 3

To qualify for Level 3 care, the patient must meet criteria for either C-1 or C-2, as described below.

C-1: In addition to meeting all requirements for Level 1, the patient requires one or more of services (1) through (4) listed below:

1. Hemodialysis
2. Ventilator care
3. Expanded spectrum IV antibiotics for subacute and Skilled Nursing Facilities (SNFs)
4. Rehabilitation residential transitional living centers for post-acute rehabilitation services; such programs must meet the patient treatment and discharge plan requirements, and must include four to six hours per day of skilled physical, occupational, speech or neuropsychological therapy

C-2: To qualify for Level 2 care, in addition to meeting all requirements for Level 1, the patient requires three or more services from items numbered (1) through (7) from Level 2.

Billing instructions and requirements:

1. Utilization Management approval is required for admission.
2. A revenue code must be included for the approved subacute care level. The appropriate revenue code for Level 3 is 0193 or 0194.

4. Psychiatric Inpatient Services

The billing requirements for psychiatric inpatient services apply to each approved and Medically Necessary service day in a duly licensed acute psychiatric bed, and includes all services rendered during an admission, including, but not limited to: room and board (includes all nursing care and non-physician professional services), surgery and recovery suites, laboratory, radiology, equipment use, supplies, imaging services, pharmaceuticals, observation services, and other services incidental to the admission. Psychiatric inpatient services also include inpatient services, including, but not limited to, group therapy, biofeedback educational lectures and/or materials, 23-hour stabilization, and electro-convulsive therapy.

Billing instructions and requirements:

1. ICD-10-CM diagnosis codes must be included for each care level. The appropriate ICD-10-CM codes are, except:
   - Utilization Management approval is required for all admissions (except Individual and Small Group).

5. Chemical Dependency Inpatient Services

The billing requirements for chemical dependency inpatient services apply to each approved and Medically Necessary service day in a duly licensed, distinct part of an alcohol/chemical dependency treatment unit, and include payment for all services rendered during an admission, including, but not limited to, room and board (includes all nursing care and non-physician professional services), surgery and recovery suites, laboratory, radiology, equipment, imaging services, pharmaceuticals, observation services, narco-synthesis, aversive conditioning, group therapy, biofeedback, and other services incidental to the admission. The requirements also apply to both service days for alcohol/chemical detoxification, as well as the initial stages of rehabilitation.

Billing instructions and requirements:

1. ICD-10-CM diagnosis codes must be included for each care level.

The appropriate ICD-10-CM codes are:			
F10.121, F10.221, F10.231, F10.921, F10.26, F10.96, F10.97, F10.27, F10.151, F10.251, F10.951, F10.920, F10.929, F10.150, F10.250, F10.950	F14.20-F14.21	F19.20-F19.21	F14.10, F14.120, F14.90
F10.230, F10.232, F10.239, F10.182, F10.282, F10.982, F10.14, F10.159, F10.180, F10.181, F10.188, F10.24, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F10.19, F10.29, F10.94, F10.99	F12.20-F12.21	F10.10, F10.120, F10.129	F15.10, F15.120, F15.90
F11.23, F11.93, F13.93, F13.230, F13.231, F13.232, F13.239, F13.930, F13.931, F13.932, F13.939, F14.23, F15.23, F15.93, F17.203, F17.213, F17.223, F17.293, F18.259, F18.280, F18.288, F18.959, F18.980, F18.988, F19.122, F19.159, F19.180, F19.181, F19.188, F19.222, F19.259, F19.280, F19.281, F19.288, F19.922, F19.959, F19.980, F19.981, F19.988, F11.19, F11.29, F11.99, F12.19, F12.29, F12.99, F13.19,	F15.20-F15.21	F17.200-F17.201, F17.210-F17.211, F17.220-F17.221, F17.290-F17.291	F19.10, F19.120, F19.90

F13.29, F13.99, F14.19, F14.29, F14.99, F15.19, F15.29, F15.99, F16.19, F16.29, F16.99, F17.209, F17.219, F17.229, F17.299, F18.19, F18.29, F18.99, F19.19, F19.29, F19.99, F19.230, F19.231, F19.232, F19.239, F19.930, F19.931, F19.932, F19.939, F11.150, F11.250, F11.950, F12.150, F12.250, F12.950, F13.150, F13.250, F13.950, F14.150, F14.250, F14.950, F15.150, F15.250, F15.950, F16.150, F16.250, F16.950, F18.150, F18.250, F18.950, F19.150, F19.250, F19.950, F11.151, F11.251, F11.951, F12.151, F12.251, F12.951, F13.151, F13.251, F13.951, F14.151, F14.251, F14.951, F15.151, F15.251, F15.951, F16.151, F16.251, F16.951, F18.151, F18.251, F18.951, F19.151, F19.251, F19.951, F11.220, F11.229, F11.920, F11.929, F12.120, F12.129, F12.220, F12.229, F12.920, F12.929, F13.129, F13.220, F13.229, F13.920, F13.929,			

F14.129, F14.220, F14.229, F14.920, F14.929, F15.129, F15.220, F15.229, F15.920, F15.929, F16.129, F16.220, F16.229, F16.920, F16.929, F18.120, F18.129, F18.220, F18.229, F18.920, F18.929, F19.129, F19.220, F19.229, F19.920, F19.929, F11.121, F11.221, F11.921, F12.121, F12.221, F12.921, F13.121, F13.221, F13.921, F14.121, F14.221, F14.921, F15.121, F15.221, F15.921, F16.121, F16.221, F16.921, F18.121, F18.221, F18.921, F19.121, F19.221, F19.921, F16.220, F16.229, F16.920, F16.929, F18.120, F18.129, F18.220, F18.229, F18.920, F18.929, F19.129, F19.220, F19.229, F19.920, F19.929, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27 F19.97, F13.26, F13.96, F19.16, F19.26, F19.96, F11.14, F11.24, F11.94, F13.14, F13.24, F13.94, F14.14, F14.24, F14.94, F15.14, F15.24, F15.94, F16.14, F16.24,			

F16.94, F18.14, F18.24, F18.94, F19.14, F19.24, F19.94, F11.182, F11.282, F11.982, F13.182, F13.282, F13.982, F14.182, F14.282, F14.982, F15.182, F15.282, F15.982, F19.182, F19.282, F19.982, F11.122, F11.159, F11.181, F11.188, F11.222, F11.259, F11.281, F11.288, F11.922, F11.959, F11.981, F11.988, F12.122, F12.159, F12.180, F12.188, F12.222, F12.259, F12.280, F12.288, F12.922, F12.959, F12.980, F12.988, F13.159, F13.180, F13.181, F13.188, F13.259, F13.280, F13.281, F13.288, F13.959, F13.980, F13.981, F13.988, F14.122, F14.159, F14.180, F14.181, F14.188, F14.222, F14.259, F14.280, F14.281, F14.288, F14.922, F14.959, F14.980, F14.981, F14.988, F15.122, F15.159, F15.180, F15.181, F15.188, F15.222, F15.259, F15.280, F15.281, F15.288, F15.922, F15.959, F15.980, F15.981, F15.988, F16.122, F16.159, F16.180, F16.183,			

F16.188, F16.259, F16.280, F16.283, F16.288, F16.959, F16.980, F16.983, F16.988, F17.208, F17.218, F17.228, F17.298, F18.159, F18.180, F18.188			
F10.220, F10.229	F16.20-F16.21	F12.10, F12.90	F18.10, F18.120, F18.90, F55.0-F55.8
F10.20-F10.21	F18.21, F19.20-F19.21	F16.10, F16.120, F16.90	
F11.20-F11.21	F19.20-F19.21	F13.10, F13.120, F13.90	
F13.20-F13.21	F19.20-F19.21	F11.10, F11.120, F11.129, F11.90	

Utilization Management approval is required for all admissions (except Individual and Small Group).

6. Psychiatric Outpatient/Residential Services

The billing requirements for psychiatric outpatient/residential services apply to each approved and Medically Necessary service date in a licensed psychiatric outpatient/residential program, and include payment for all services rendered during a psychiatric outpatient/residential visit including, but not limited to, Facility use (that includes all nursing care and non physician professional services), professional services provided or arranged by Facility, laboratory, radiology, supplies, equipment, imaging services, pharmaceuticals, observation services and all other services incidental to the outpatient/residential visit. A psychiatric outpatient/residential visit means a single service date. For purposes of applying the lesser of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Anthem has created Levels of Care for this service category. These levels differ in terms of the degree of services required, as defined by the combination of ICD-10-CM diagnosis codes and revenue codes.

Defining Levels of Care

Level 1

Intensive outpatient structured program (three to five hours per day – a minimum of 3 days per week); Level 1 is the default, unless Level 2 is approved by Utilization Management.

Level 2

This includes partial hospitalization (six to eight hours per day – a minimum of 5 days per week, six to eight hours per day also applies to programs with a Saturday and Sunday program). This also includes outpatient electroconvulsive therapy. All Level 2 care requires Utilization Review approval/certification.

Billing instructions and requirements:

1. ICD-10-CM diagnosis codes must be included for each care level. The appropriate ICD-10-CM codes are. [missing text here?]
2. Revenue codes must be included for each care level. Appropriate revenue codes are 0901, 0911-0914, 0944 or 0945. These codes are not necessarily applicable to FEP.
3. Utilization Management must approve the level of care for all services. An authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.
5. Whole hours must be used to indicate hours of care in the "Service Units" field. Show whole hours in form locator 46.

7. Chemical Dependency Outpatient/Residential Services

The billing requirements for chemical dependency outpatient/residential services apply to all Medically Necessary service days in a licensed alcohol/chemical dependency treatment program, and include payment for all services rendered during an alcohol/chemical dependency outpatient/residential visit, including, but not limited to, Facility use (that includes all nursing care and non physician professional services), professional services provided or arranged by Facility, laboratory, radiology, supplies, equipment, imaging services, telemetry services, pharmaceuticals, observation services and all other services incidental to the outpatient/residential visit. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Anthem has created Levels of Care for this service category, and they differ in terms of the degree of services required. For billing purposes, these levels are defined by the ICD-10-CM diagnosis codes billed to Anthem.

Defining Levels of Care

Level 1

Intensive outpatient structured programs (three to five hours per day – a minimum of 3 days per week); Level 1 is the default, unless Level 2 is approved by Utilization Management.

Level 2

This includes partial hospitalization (six to eight hours per day – a minimum of 5 days per week, six to eight hours also applies to programs with a Saturday/Sunday program) and outpatient detoxification.

Billing instructions and requirements:

1. ICD-10-CM diagnosis codes must be included for each care level.

The appropriate ICD-10-CM codes are:			
F10.121, F10.221, F10.231, F10.921, F10.26, F10.96, F10.97, F10.27, F10.151, F10.251, F10.951, F10.920, F10.929, F10.150, F10.250, F10.950	F14.20-F14.21	F19.20-F19.21	F14.10, F14.120, F14.90
F10.230, F10.232, F10.239, F10.182, F10.282, F10.982, F10.14, F10.159, F10.180, F10.181, F10.188, F10.24, F10.259, F10.280, F10.281, F10.288, F10.959, F10.980, F10.981, F10.988, F10.19, F10.29, F10.94, F10.99	F12.20-F12.21	F10.10, F10.120, F10.129	F15.10, F15.120, F15.90
, F11.23, F11.93, F13.93, F13.230, F13.231, F13.232, F13.239, F13.930, F13.931, F13.932, F13.939, F14.23, F15.23, F15.93, F17.203, F17.213, F17.223, F17.293, F18.259, F18.280, F18.288, F18.959, F18.980, F18.988, F19.122, F19.159, F19.180, F19.181, F19.188, F19.222, F19.259, F19.280, F19.281, F19.288, F19.922, F19.959, F19.980, F19.981, F19.988, F11.19, F11.29, F11.99, F12.19, F12.29, F12.99, F13.19, F13.29, F13.99,	F15.20-F15.21	F17.200-F17.201, F17.210-F17.211, F17.220-F17.221, F17.290-F17.291	F19.10, F19.120, F19.90

F14.19, F14.29, F14.99, F15.19, F15.29, F15.99, F16.19, F16.29, F16.99, F17.209, F17.219, F17.229, F17.299, F18.19, F18.29, F18.99, F19.19, F19.29, F19.99, F19.230, F19.231, F19.232, F19.239, F19.930, F19.931, F19.932, F19.939, F11.150, F11.250, F11.950, F12.150, F12.250, F12.950, F13.150, F13.250, F13.950, F14.150, F14.250, F14.950, F15.150, F15.250, F15.950, F16.150, F16.250, F16.950, F18.150, F18.250, F18.950, F19.150, F19.250, F19.950, F11.151, F11.251, F11.951, F12.151, F12.251, F12.951, F13.151, F13.251, F13.951, F14.151, F14.251, F14.951, F15.151, F15.251, F15.951, F16.151, F16.251, F16.951, F18.151, F18.251, F18.951, F19.151, F19.251, F19.951, F11.220, F11.229, F11.920, F11.929, F12.120, F12.129, F12.220, F12.229, F12.920, F12.929, F13.129, F13.220, F13.229, F13.920, F13.929, F14.129, F14.220,			

F14.229, F14.920, F14.929, F15.129, F15.220, F15.229, F15.920, F15.929, F16.129, F16.220, F16.229, F16.920, F16.929, F18.120, F18.129, F18.220, F18.229, F18.920, F18.929, F19.129, F19.220, F19.229, F19.920, F19.929, F11.121, F11.221, F11.921, F12.121, F12.221, F12.921, F13.121, F13.221, F13.921, F14.121, F14.221, F14.921, F15.121, F15.221, F15.921, F16.121, F16.221, F16.921, F18.121, F18.221, F18.921, F19.121, F19.221, F19.921, F16.220, F16.229, F16.920, F16.929, F18.120, F18.129, F18.220, F18.229, F18.920, F18.929, F19.129, F19.220, F19.229, F19.920, F19.929, F13.27, F13.97, F18.17, F18.27, F18.97, F19.17, F19.27, F19.97, F13.26, F13.96, F19.16, F19.26, F19.96, F11.14, F11.24, F11.94, F13.14, F13.24, F13.94, F14.14, F14.24, F14.94, F15.14, F15.24, F15.94, F16.14, F16.24, F16.94, F18.14,			

F18.24, F18.94, F19.14, F19.24, F19.94, F11.182, F11.282, F11.982, F13.182, F13.282, F13.982, F14.182, F14.282, F14.982, F15.182, F15.282, F15.982, F19.182, F19.282, F19.982, F11.122, F11.159, F11.181, F11.188, F11.222, F11.259, F11.281, F11.288, F11.922, F11.959, F11.981, F11.988, F12.122, F12.159, F12.180, F12.188, F12.222, F12.259, F12.280, F12.288, F12.922, F12.959, F12.980, F12.988, F13.159, F13.180, F13.181, F13.188, F13.259, F13.280, F13.281, F13.288, F13.959, F13.980, F13.981, F13.988, F14.122, F14.159, F14.180, F14.181, F14.188, F14.222, F14.259, F14.280, F14.281, F14.288, F14.922, F14.959, F14.980, F14.981, F14.988, F15.122, F15.159, F15.180, F15.181, F15.188, F15.222, F15.259, F15.280, F15.281, F15.288, F15.922, F15.959, F15.980, F15.981, F15.988, F16.122, F16.159, F16.180, F16.183, F16.188, F16.259,			

F16.280, F16.283, F16.288, F16.959, F16.980, F16.983, F16.988, F17.208, F17.218, F17.228, F17.298, F18.159, F18.180, F18.188			
F10.220, F10.229	F16.20-F16.21	F12.10, F12.90	F18.10, F18.120, F18.90, F55.0-F55.8
F10.20-F10.21	F18.21, F19.20-F19.21	F16.10, F16.120, F16.90	
F11.20-F11.21	F19.20-F19.21	F13.10, F13.120, F13.90	
F13.20-F13.21	F19.20-F19.21	F11.10, F11.120, F11.129, F11.90	

2. The required and appropriate revenue codes are 0911-0914, 0944 and 0945.
3. Utilization Management must approve the level of care for all services. The authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.
5. Whole hours indicating hours of care must be supplied in the “Service Units” field. Show whole hours in form locator 46 of the *UB-04 Claim* form.

8. Outpatient Surgical Services

The billing requirements for outpatient surgical services apply to each outpatient Hospital visit for outpatient surgery services, including, but not limited to, Facility use (includes nursing care and non physician professional services), professional services provided or arranged by Facility, equipment, supplies, pharmaceuticals, blood and blood product administration, laboratory, radiology, imaging services, telemetry services, observation services, implantable prostheses or orthotics, recovery room services, and all other services incidental to the outpatient surgery visit. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility’s total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

! Facility is not entitled to additional reimbursement based on the fact that a bilateral surgical procedure was performed on the Member. Therefore, the use of the CPT Modifier 50 will not result in additional reimbursement. The Facility’s reimbursement is limited to the one highest applicable outpatient surgical grouper.

The billing requirements are based on the highest grouping submitted. See the CD labeled Fee Schedules and CPT4/HCPCS Codes in order to view “Outpatient Surgical Groupings.” For surgery services that are

not defined in the surgery grouping, medical records might be requested by Anthem's Medical Department for review and determination of surgery grouping.

Billing instructions and requirements:

1. CPT4/HCPCS codes must be included for each surgical procedure in form locators 44 (HCPCS/RATES). Revenue codes 036X, 0480, 0481, 0490, 070X, 071X, 075X, 076X and 079X are required with the appropriate CPT4/HCPCS code.
2. Effective October 16, 2003, HIPAA mandates that outpatient surgery be billed with CPT4/HCPCS code.
3. Service dates must accompany each procedure (both principal and other).

9. Emergency Room Visits

The billing requirements for an emergency room visit apply to all emergency cases initially treated in the Hospital emergency room. The Anthem Rate for emergency services resulting from an Emergency condition applies to all emergency cases/visits initially treated in the Facility's emergency room, and no matter where in the Facility the Member is discharged from (except those where the Member is subsequently admitted as an inpatient in which case the inpatient rate shall apply in lieu of the Anthem Rate for emergency services), and includes payment-in-full for all diagnostic and therapeutic services provided including, but not limited to: Facility use, professional services provided or arranged by Facility, monitoring, equipment (e.g., MRI, CT, etc.), laboratory, observation services, recovery suites, radiology, imaging services, telemetry services, supplies, pharmaceuticals, blood, blood product administration, staff charges, non physician professional services, and any other services incidental to the emergency services visit, whether provided in the emergency room or not and whether or not the Member is discharged from the Emergency Department or elsewhere in the Facility. Reimbursement for emergency room services relates to the emergency diagnosis and can be based on urgent care rates, depending on the diagnosis. Emergency services are services provided in connection with the initial treatment of a medical or psychiatric emergency. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Emergency means a sudden, serious and unexpected onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, sudden and unexpected, severe pain); such that the patient may reasonably believe that the absence of immediate medical attention could result in any of the following:

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions
3. Other serious medical or psychiatric consequences, or
4. Serious and/or permanent dysfunction of any bodily organ or part

If the emergency room visit results in an admission, then all services provided in the emergency room must be billed in conformity with the guidelines and requirements for inpatient acute care.

Billing instructions and requirements:

1. ICD-10-CM principal diagnosis codes are required for all services provided in an emergency room setting.
2. Each service date must be billed as a separate line item.
3. Revenue codes are 0450 to 0452, 0459 and the appropriate CPT4/HCPCS code.

10. Urgent Care Visits

The billing requirements for urgent care visits apply to all urgent care cases initially treated in the Facility's, Outpatient Department/Emergency Room/Urgent Care clinic, and no matter where in the Facility the Member is discharged from and include all diagnostic and therapeutic services provided including, but not limited to: Facility use, professional services provided or arranged by Facility, monitoring, equipment (e.g., MRI, CT, etc.), laboratory, observation services, recovery suites, radiology, imaging services, telemetry services, supplies, pharmaceuticals, blood, blood product administration, staff charges, non-physician professional services and any other services incidental to the urgent care visit, no matter where in the Facility the services are provided. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Urgent care refers to nonscheduled, non-emergency Hospital services required to prevent serious deterioration of a patient's health status as a result of an unforeseen illness or injury. Urgent care visits do not apply to those cases that are admitted and treated for inpatient care following urgent care treatment.

Billing instructions and requirements:

1. ICD-10-CM principle diagnosis codes are required for all services provided in an urgent care setting or designated Facility.
2. Each service date must be billed as a separate line item.
3. Revenue codes required are 045X, 0516, 0526, 0700 or 072X.

11. Outpatient Laboratory, Radiology and Diagnostic Services

The billing requirements for outpatient laboratory, radiology and diagnostic services (not included elsewhere) refer to services that include, but are not limited to, clinical laboratory, pathology, radiology and other diagnostic tests. These billing requirements include services rendered in relation to an outpatient visit for laboratory, radiology or other diagnostic services, including, but not limited to: Facility use, recovery suites, nursing care (including incremental nursing), equipment, non-physician professional services (if applicable), specified supplies and all other services incidental to the outpatient visit. The Anthem Rate also includes outpatient radiation therapy services unless that service is included elsewhere as part of another negotiated Anthem Rate in your Agreement with Anthem. See the CD labeled Fee Schedules in order to view outpatient laboratory, radiology and other diagnostic services fee schedules (technical component only).

Billing instructions and requirements:

1. CPT4/HCPCS codes are required for each service.
2. Each service for each date must be billed as a separate line item.
3. The following revenue codes should be used with the appropriate CPT4/HCPCS code:

0300 – 0302	0340 – 0341	061X
0305 – 0309	0349	073X
031X	035X	

4. When the Respiratory Therapy department performs Electrocardiograms and Electroencephalograms, follow the billing requirements as outlined in this service category. Do not apply the *Outpatient Therapy* billing requirements.
5. The type of bill field entry must be 13X.

12. Outpatient Therapies

Outpatient therapy services include physical therapy, occupational therapy, speech therapy and respiratory therapy. An outpatient therapy visit means a single service date. Outpatient therapy visits include, but are not limited to, Facility use (includes all nursing care), therapist/non-physician professional services, supplies, equipment, recovery suites, imaging services, pharmaceuticals and other services incidental to the outpatient therapy visit. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Billing instructions and requirements:

1. Each service date must be billed as a separate line item.
2. Required revenue codes are:
   - Physical therapy – 042X
   - Occupational therapy – 043X
   - Speech therapy – 044X
   - Respiratory therapy – 041X
3. Or the applicable HCPCS/CPT4 codes

13. Outpatient Infusion Therapy Visit and Pharmaceuticals

The outpatient infusion therapy visit billing requirements apply to each outpatient Hospital visit for infusion therapy services, including, but not limited to, Facility use (includes all nursing care), recovery suites, equipment, non-physician professional services, laboratory, radiology, imaging services, supplies (e.g., syringes, tubing, line-insertion kits, etc.), intravenous solutions (excluding pharmaceuticals), kinetic dosing and other services incidental to the outpatient infusion therapy visit. An outpatient infusion therapy visit means a single service date. For purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

The outpatient infusion therapy pharmaceuticals billing requirements apply to the drugs (e.g., chemotherapy, hydration and antibiotics) used during each outpatient visit for infusion therapy services, except for blood and blood products, which are considered other services.

Billing instructions and requirements:

1. Revenue codes 026X, 028X, 0331-0332 or 0335 with applicable HCPCS codes are required for each outpatient infusion therapy visit.
2. The applicable CPT/ HCPCS codes are 36511-36516, 36430, 96401-96402, 96405-96406, 96409, 96411, 96413, 96415-96417, 96450, Q0081, C8957, 96360-96376, and 96446.
3. Pharmaceuticals should be listed as separate line items. The CPT/HCPCS codes must be billed for each drug including the units per date of service.
4. When using an unlisted CPT4/HCPCS code, provide the name of the drug or medication in form locator 43 of the *UB-04 Claim* form.

14. Hospice Care

This service category is used when a Member elects to no longer have the usual acute care Hospital services. The Member is electing care provided by the Visiting Nurses Association (VNA). These Claims create a new Claim if the previous Claim was in Stop Loss. If the Visiting Nurses Association does not have a commercial contract with the Hospital for services. The Hospital must work with VNA and Anthem to establish a contract for the patient or transfer the patient to the nearest Facility providing Hospice Care. Note: Federal Employee benefits are available for inpatient and in-home hospice care provided to Members with a projected life expectancy of six (6) months or less due to a terminal medical condition when rendered by a plan approved Hospice Provider. Prior approval and Case Management are required.

15. Subacute Care

This service is provided to patients who no longer benefit from acute care or ICU. Once moved to acute care level of service, a new Claim must be issued. Subacute care is not eligible to be included in a Stop Loss Claim.

16. Hospitality Day

This does not apply to FEP; it is not a covered benefit of the FEP.

The hospitality day is specific only to the one day prior to a scheduled surgery when the patient is accommodated in the Hospital or an associated Facility. The purpose of the hospitality day is to allow reimbursement for scheduled and approved preoperative stays. Such stays may not have a Medically Necessary basis for an admission prior to surgery, but Members may otherwise experience a hardship without this provision.

Billing instructions and requirements:

1. The only valid revenue code for a hospitality day is 0167 (this is an Anthem-specific revenue code).
2. Eligibility is limited to Members who:
   - Are required by the Hospital to report for surgery prior to 8 am, the day of surgery
   - Reside over 50 miles or 45 minutes travel time from the Hospital
   - Have received prior authorization; the Hospital will not be eligible to receive reimbursement for preoperative days at a hospitality day rate without three days prior authorization from Utilization Management.

3. Retroactive approval of a hospitality day rate for a preoperative day will not be provided, nor may the Hospital bill a Member admitted under a preoperative hospitality day rate for a denied hospitality preoperative day.
4. Current Anthem policy says that Claims for diagnostic testing performed the day prior to surgery, while the Member is in the Hospital at a hospitality day rate, should be submitted as part of the inpatient services. Anthem reimburses the Hospital for Medically Necessary laboratory services covered under the Member's Benefit Agreement while the Member is occupying a preoperative bed for an approved stay, according to the Agreement.

17. Other Services

Other services include most of the services rendered by the Hospital that are not covered under the specific service categories set forth elsewhere in this Manual.

This category is meant for those rare service types that do not reasonably fall under any other specific reimbursement rate or considered inclusive to specific services.

Billing instructions and requirements:

1. Follow the procedures discussed in the *General Billing Requirements* subsection and always provide all the applicable codes and service dates.
2. In addition to revenue codes, CPT4/HCPCS codes must be provided. Failing to do so may result in denial of payment.

In addition to the specific categories of services above where we note how the lessor of calculation will be performed, any other categories that are reimbursed on a per date of service/per visit basis, per diem or per case rate basis will be calculated similarly. That is, for purposes of applying the lessor of calculation to determine the eligible reimbursement amount (i.e., lesser of the applicable Anthem Rate or the Facility's total Covered Billed Charges), all service dates/visits submitted on a claim will be included (exclusive of carve-outs, as applicable). Therefore, the lesser of calculation shall be based on all charges billed on a single claim (and not separated out on a per date of service/visit basis).

Billing Reference

Used with the following references, the Facility Provider Manual provides detailed instructions on uniform billing requirements:

- *CPT* (current edition), American Medical Association. To order, call toll-free 1-800-621-8335.
- *CMS Healthcare Common Procedure Coding System* (HCPCS), *National Level II* (current edition). To order, call toll-free 1-800-633-7467.
- *ICD-10 CM* (current edition), Volumes 1, 2, 3 (current year), Practice Management Information Corporation. To order, call toll-free 1-800-633-7467.
- *UB-04 Data Specifications Manual (Current Edition), National Uniform Billing Committee (NUBC).* To order, go to their website nubc.org. If you have questions, call 1-312-422-3390.

Medicaid Reclamation – Senate Bill 853B

Effective October 19, 2010, professional and institutional Providers were allowed to submit Medicaid Reclamation Claims directly to commercial health plans instead of billing Medicaid directly. Accordingly,

Providers are given three years to submit these Claims and are allowed six years to submit any Medicaid Reclamation adjustment Claims to Anthem.

Important Change: Beginning in 2012, Providers must submit the following text in the "remarks" field for paper Claims and the "notes" field for electronic Claims: "Waive Timely Filing Medicaid Reclamation." Any deviation from this specific language may cause a delay in Provider payment.

For paper Claims, the note text must be submitted as follows:

- All institutional Claims submitted on *UB-04 Claims* form on Field box 80 (Remarks)
- All Professional Claims submitted on *CMS-1500 Claims* form on Field Box 19 (Reserved for Local Use)
- ADA Claims form on Line 35 (Remarks)

For electronic Claims, the note text must be submitted as follows:

- All institutional Claims submitted via an 837I transaction on NTE segment (Loop 2300)
- All professional Claims submitted via an 837P transaction on NTE segment (Loop 2300)
- All Dental Claims submitted via an 837D transaction on NTE segment (Loop 2300)

If you have additional questions regarding electronic Claims submission, contact your local EDI department toll-free number 1-800-227-3983. For paper Claims, contact the Provider Care department toll-free number at 1-800-677-6669.

Reimbursement Policies

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Introduction

This section provides information on pricing methods, adjudicated claims remittance and reimbursement. The discussion on reimbursement includes other payment sources, such as third-party liability and Member liability. The final topic of this section discusses the procedures to seek excess claim payments, referred to as overpayment and recovery.

Applicable Anthem Rate

The Anthem Blue Cross (Anthem) Rate shall be the rate in effect as of the date of admission (inpatient claims) or date of service (outpatient claims) for all Covered Services not based on a DRG. For all Covered Services paid based on a DRG reimbursement, the Anthem Rate shall be the DRG Rate in effect on the date of admission. The DRG Relative weights and groupings are based on the date of discharge.

Third-Party Liability

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

Anthem may have a right under the Member's Benefit Agreement to seek reimbursement for the benefits it pays for this treatment from a third party or third-party's insurer. However, neither this right to reimbursement nor the fact that Anthem may have been reimbursed, in whole or in part, for a particular benefits payment renders the medical services noncovered under the Member's Agreement.

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

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

Workers' Compensation/Other Payors Network Leasing

If the Facility believes that the Member has filed for Workers' Compensation, the Facility should verify with the insurer, self-insured employer or TPA (Other Payor) the status of the Workers' Compensation claim and confirm the surgery or procedure has been authorized by the Other Payor. The Facility should also verify that the Other Payor is participating in the network leasing by locating their name on the Other Payor Network Leasing Arrangements Workers' Compensation section. See the *Workers' Compensation* section for additional information.

Refer to *Appendix A – Other Payors List (Network Leasing)*

Note: This listing is revised monthly; therefore, refer to ProviderAccess for a current version at: https://provider2.anthem.com/wps/portal/ebpmybcc.

! IMPORTANT UPDATE ON PROVIDERACCESS®: Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will be moved to the Availity Web Portal (Availity).

Member's Liability

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

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

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

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

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

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

Coordination of Benefits

When Anthem is a secondary payor in a Coordination of Benefits (COB) situation, Anthem will pay in accordance with Title 28 of California Code of Regulations Section 1300.67.13. The Anthem payment will not exceed the negotiated rate, Total Eligible Billed Charges or the Member's responsibility for Covered Services, whichever is less. The COB discount will be applied to the secondary payment, when applicable.

Anthem's payment to a Facility will never be such that the Facility's total compensation from all sources, including Medicare, equals more than the negotiated rate. In some instances, this may mean no payment by Anthem.

In those circumstances where the Member may have other insurance coverage of any kind, Facility shall submit to Anthem the Explanation of Benefits or Explanation of Medicare Benefits that the Facility receives from the other insurer(s). Facility shall be responsible for submitting all necessary information to allow Anthem to determine the amount due to the Facility, if any, as the primary or secondary payor on a claim.

Examples of Charges Not Separately Reimbursed

The following is not meant to be an exhaustive list. These are examples only.

Courtesy/Hospitality Room – Facility shall not bill Anthem, Plan and/or Members for any charges related to use of a Courtesy/Hospitality Room in the provision of Health Services to a Member.

Different Settings Charges – If Anthem determines that Facility submits charges differently for the same service performed in a different setting, Plan will reimburse the lesser of the two charges.

General Industry Standard Language – Per Anthem policy and the Agreement, Facility will follow industry standards related to billing. Examples of general industry standards include, but are not limited to, HCPCS, ICD9/CM, ICD10/CM, health service codes (also known as Revenue Codes) per the *UB-04 Claim* billing manual or subsequent forms CPT codes.

Instrument Trays and/or Surgical Packs – Charges for instrument trays and/or surgical packs for any procedure or surgery are included in the cost of the procedure or surgery and are not separately reimbursable.

IV Sedation and Local Anesthesia – Administered by the Facility performing the procedure, and/or nursing personnel, is not separately reimbursable.

Lab Charges – Venipuncture (CPT Code 36415, 36416 or G0001), specimen collection, draw fees, phlebotomy, heel stick, processing fees, handling fees, blood storage and processing, blood administration. These charges are inclusive of the procedure/lab test performed and not separately billable.

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, blood transfusion administration/monitoring, Point of Care/Bedside Testing (such as glucose, blood count, arterial blood gas, clotting time, etc.), subcutaneous (SQ) injections and nasogastric tube (NGT) insertion or catheter insertion.

Other Agreements Excepted – If Facility currently maintains a separate Agreement(s) with Anthem Blue Cross solely for the provision and payment of home health care services, Skilled Nursing Facility (SNF), Transplant Services, ambulatory surgical Facility services, or other Agreements that Anthem Blue Cross designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered thereunder.

Other Special Charges – Observations hours may never exceed the charge of a semiprivate daily room charge. If the daily fee for a semiprivate room is $2500.00 the observations hours charged for 24 hours cannot exceed $2500.00 for any given day. The ventilator charge should include the charge of the oxygen it

is delivering. Oxygen may not be charged separately when a patient is on a ventilator. Respiratory assessment charges are not separately billable. This charge is considered to be part of the charge of the equipment being used.

Personal Care Items – Personal care items used for patient convenience are not reimbursable. Examples include, but are not limited to: deodorant, dry bath, dry shampoo, lotion, non-medical personnel, mouthwash, powder, soap, telephone calls, television, tissues, toothbrush and toothpaste. Items used for the patient, which are needed as a direct result of a procedure or test, are considered part of the room and board or procedure charges, and are not separately reimbursable or billable to the patient. Examples include, but are not limited to: bedpans, chux, hot water bottles, icepacks, sitz baths and urinals.

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

Preoperative Care or Holding Room Charges – Charges for a preoperative (pre-op) care or holding room used prior to a procedure are included in the reimbursement for the procedure charge and are not reimbursed separately. Nursing care provided in the preoperative 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.

Special Procedure Room Charge – Special procedure room charges are included in the reimbursement for the procedure. If the procedure takes place outside of the OR suite, then OR time cannot be billed separately to cover OR personnel/staff being present in the room. Example: ICU, GI lab, etc.

Stand-by Charges – Stand-by equipment and consumable items such as oxygen, which are on stand-by, are not reimbursable. Only actual use is covered. Professional staffs on stand-by are included in the reimbursement for the procedure and also are not separately reimbursable.

Stat Charges – Stat charges are included in the reimbursement for the procedure, test and/or X-ray. No additional charges for stat services will be allowed.

Supplies and Equipment – Charges for medical equipment, IV pumps, PCA Pumps, and isolation carts and supplies are not separately billable.

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. Transporting a patient back to their room following surgery, a procedure, or test.

Undocumented or Unsupported Charges – Plan will not reimburse charges that are not documented on medical records or supported with reasonable documentation.

Video Equipment Used in Operating Room – Charges for video equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges for batteries, covers, film, anti-fogger solution, tapes, etc., are not separately reimbursable.

Disallowed Charges

Only Eligible Billed Charges for Covered Services are eligible for reimbursement. In addition to those identified above, 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:

Provider 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)
0220	Special Charges
0369	Preoperative Care or Holding Room Charges
0760 – 0769	Special Procedure Room Charge
0111 – 0119	Private Room* (subject to Member's Benefit)
0221	Admission Charge
0480 – 0489	Percutaneous Transluminal Coronary Angioplasty (PTCA) Stand-by Charges
0220, 0949	Stat Charges
0270 – 0279, 0360	Video Equipment Used in Operating Room

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0270, 0271, 0272	Nasal Cannula; Foley stat lock; Blood Pressure cuffs; SCD Sleeves/Compression Sleeves; Ted hose; Pulse oximeter probes; Oral swabs/toothettes; Urine collection unit/containers/urinals; Isolation supplies; Tapes; Band aids; Telfa; Dressing Sponge; Gauze Sponge; Tegaderm; Opsite; IV start kits and IV supplies: tubing, extensions, angio-catheters, blood IV tubing; Specimen traps; Skin cleansers; Gloves; Pads sanitary; ID bracelets/allergy bracelets; Adult diapers or briefs; Gowns; Drapes; Kits; Sterile towel packs; Specimen containers; Basins/basin sets; Skin staplers/removers; Sutures; Lap sponges/raytecs; Suction tubing/suction tips; Dressings: (Telfa; Band aid; tegaderm; opsite; kerlix); Tapes; Prep/prep trays; Masks; Shoe covers; Hoods; Tip suction Yankauer; Bonnets/Hats
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 Special Charges • Observations hours may never exceed the charge of a semiprivate room charge • Oxygen charges while a patient is on a ventilator • Respiratory assessment charges

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0230, 0270 – 0272, 0300 – 0307, 0309, 0390-0392, 0310	Nursing Procedures and 99001 – Handling and/or conveyance of specimen from patient (charge for specimen handling)
0230	Incremental Nursing – General
0231	Nursing Charge – Nursery
0232	Nursing Charge – Obstetrics (OB)
0233	Nursing Charge – Intensive Care Unit (ICU)
0234	Nursing Charge – Cardiac Care Unit (CCU)
0235	Nursing Charge – Hospice
0239	Nursing Charge – Emergency Room (ER) or Post Anesthesia Care Unit (PACU) or Operating Room (OR)
0250 – 0259, 0636	Pharmacy (non-formulary drugs, compounding fees, nonspecific descriptions) • Medication prep • Nonspecific descriptions
0256	Experimental Drugs
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 (Rev codes 0380, 0390 – 0392; 0399)

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0222, 0270, 0272, 0410, 0460	Portable Charges
0270 – 0279, 0290, 0320, 0410, 0460	Supplies and Equipment • Preparation (Set-up) Charges; Set-up is included in the fee for the procedure and, as such, included in the room and board • Instrument Trays and/or Surgical Packs • IV pumps and PCA (Patient Contrlled Analgesia) pumps • Isolation supplies • Blood Pressure Monitor • Beds • SCD Pumps • Cardiac Monitor • C-Arm/Fluoroscopic Charge • Wound Vacuum Pump • Bovie/Electro Cautery Unit • Wall Suction • Retractors • Single Instruments • Oximeter Monitor • CPM Machines • Lasers • Davinic Machine/Robot
0309 – 0369, 0419, 0619	After Hours – Call-back

Provider Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
0370 – 0379, 0410, 0460, 0480 – 0489	Anesthesia (Specifically, conscious/moderate sedation) • Nursing care • Monitoring • Intervention • Pre- or Post-evaluation and education • IV sedation and local anesthesia
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, glucose, 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

* Subject to the Member's Benefit Agreement.

Member Responsibility	
Typically Billed Under This/These Revenue Codes but not Limited to the Revenue Codes Listed Below	Description of Excluded Items
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

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Emergency Services

The Emergency Department (ED) is a Hospital-owned location or department for the provision of unscheduled episodic services to patients who present for immediate medical attention. Services rendered to a patient in the ED usually do not exceed 24 hours.

Emergency Department level of service is determined by the intervention(s) that are performed in relationship to the intensity of medical care required by the presenting symptoms and resulting diagnosis of the patient:

Straight Forward Complexity (99281/G0380): The presented problem(s) are self-limited or minor conditions with no medications or home treatment required, signs and symptoms of wound infection explained; return to ED if problems develop.

Low Complexity (99282/G0381): The presented problem(s) are of low to moderate severity. Over-the-counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily.

Moderate Complexity (99283/G0382): The presented problem(s) are of moderate severity. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication

with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.

Moderate-High Complexity (99284/G0383): The presented problem(s) are of high severity, and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.

High Complexity (99285/G0384): The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. Multiple prescription medications and/or home therapies with review of side effects and potential adverse reactions; diabetic, seizure or asthma teaching in compromised or non-compliant patients; patient/caregiver may demonstrate difficulty understanding instructions and may require additional directions to support compliance with prescribed treatment.

The payment, if any, for Emergency Department (ED) Services is specified in the Provider Agreement. Anthem requires that the patient's medical record documentation for diagnosis and treatment in the ED must indicate the presenting symptoms, diagnoses and treatment plan and requires a written order by the physician clearly documented in the medical record.

A Current Procedural Terminology (CPT®) Code or a Healthcare Common Procedure Coding System (HCPCS®) Code for Evaluation and Management (E&M) must be billed for the complexity of service that occurred during the patient encounter at the ED. Anthem defines the complexity level of service for the E&M codes as described in the table below.

The table below provides criteria that Anthem will use to determine the level of reimbursement as applicable for ED services. The table lists the E&M codes and defines the levels. Each level provides procedure and clinical examples that align with the complexity level to assist the Facility in understanding the meaning of the descriptors used to define the level of E&M service.

The procedure and clinical examples in the table are not an all-inclusive list. The highest level E&M code for which a claim clinically qualifies will be used to determine the level of reimbursement, as applicable for ED services.

CPT® 99281/HCPCS® G0380 Straight Forward Complexity	
The presented problem(s) are self-limited or minor conditions with no medications or home treatment required, signs and symptoms of wound infection explained, return to ED if problems develop.	
Procedure Examples	Clinical Examples
Triage only	Insect bite (uncomplicated)
No medication or treatment	Read Tb test

CPT® 99281/HCPCS® G0380 Straight Forward Complexity	
The presented problem(s) are self-limited or minor conditions with no medications or home treatment required, signs and symptoms of wound infection explained, return to ED if problems develop.	
Procedure Examples	Clinical Examples
Wound Check-simple	
Steri-Strip wound	
Booster or follow up immunization – no acute injury	
Dressing change (uncomplicated)	
Prescription refill	
Suture removal (uncomplicated)	

CPT® 99282/HCPCS® G0381 Low Complexity	
The presented problem(s) are of low to moderate severity. Over-the-counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily.	
Procedure Examples	Clinical Examples
Simple trauma – no X-rays	Localized skin rash, lesion, sunburn
Cast removal	Minor viral infection
Epistaxis – no packing	Eye discharge – painless
Dental pain	Urinary frequency without fever
Basic specimen testing: Accucheck, dipstick, UA clean catch	Ear pain (otitis media, sinusitis, vertigo, swimmer's ear, TMJ)
I&D of simple abscess	

CPT® 99282/HCPCS® G0381 Low Complexity	
The presented problem(s) are of low to moderate severity. Over-the-counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily.	
Procedure Examples	Clinical Examples
Assisting MD with any exam	
Venipuncture of lab	
Visual acuity exam	

CPT® 99282/HCPCS® G0381 Low Complexity	
The presented problem(s) are of low to moderate severity. Over-the-counter (OTC) medications or treatment, simple dressing changes; patient demonstrates understanding quickly and easily.	
Procedure Examples	Clinical Examples
Simple cultures (throat, skin, urine, wound)	
Simple laceration/abrasion repair (with Dermabond, without sutures)	
Simple removal of foreign body without incision or anesthetic	
Apply ace wrap or sling	
Prep or assist with procedures such as minor laceration repair	
Simple burn treatment (1st or 2nd degree)	
OTC medication administered	
EKG	

CPT® 99283/HCPCS® G0382 Moderate Complexity	
The presented problem(s) are of moderate severity. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.	
Procedure Examples	Clinical Examples
Nebulizer treatment (2 or less)	Headache (simple) – history of, no serial exam
Oxygen therapy	Head injury – without neurologic symptoms
Sprain – unable to bear weight	Cellulitis
Epistaxis with packing	Abdominal pain (Simple)
Routine trach care	Minor trauma (with potential complicating factors)
Access port catheter	Medical conditions requiring prescription drug management
Heparin/saline lock	Fever, which responds to antipyrectics
IV push medication	Eye pain (corneal abrasion or infection, blepharitis, iritis)
IV fluids without medication	Non-confirmed overdose
IM or Sub-Q medication administration	Mental Health – anxious, simple treatment
Ear or eye irrigation	Mild dyspnea – not requiring oxygen
Foley catheter insertion	GI bleed – fissure and hemorrhoid
Doppler assessment	
Prescription Medication administer – PO	
C-spine precautions	
Fluorescein stain	
Emesis/Incontinence care	

CPT® 99283/HCPCS® G0382 Moderate Complexity	
The presented problem(s) are of moderate severity. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.	
Procedure Examples	Clinical Examples
Routine psych medical clearance	
Limited social worker intervention	
Prep or assist with procedures such as joint aspiration/injection, simple, fracture care, etc	
Post mortem care	
X-ray of 2 or more body areas (not above and below joint of same limb)	
Simple dislocation of patella, finger or toes without fracture	
Assault without radiological testing	

CPT® 99284/HCPCS® G0383 Moderate-High Complexity	
The presented problem(s) are of high severity, and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.	
Procedure Examples	Clinical Examples
Blood transfusion	Headache – (complex)
Pelvic exam	Head injury with LOC
Vaginal bleeding	Abdominal pain (complex)
Nebulizer treatments – 3 or more	Chest Pain (simple)
Insertion of nasal/oral airway	Respiratory Distress

CPT® 99284/HCPCS® G0383 Moderate-High Complexity	
The presented problem(s) are of high severity, and *require urgent evaluation* by the physician but do not pose an immediate significant threat to life or physiologic function. Head injury instructions, crutch training, bending, lifting, weight-bearing limitations, prescription medication with review of side effects and potential adverse reactions; patient may have questions, but otherwise demonstrates adequate understanding of instructions either verbally or by demonstration.	
Procedure Examples	Clinical Examples
Insertion of PEG or NG tube	Blunt/penetrating trauma with limited diagnostic testing
PICC Insertion	Headache with nausea and vomiting
Use of specialized resources – social services, hearing, visual impairment, police, crisis management	Dehydration requiring treatment
Special imaging study (CT, MRI, Ultrasound, VQ scan)	Dyspnea with oxygen treatment
Cardiac monitoring	Chest pain with limited diagnostic testing
Administration and monitoring of infusion or parental medications (IV, IM, IO, SC)	Neurological symptoms: slurred speech, staggered walking, paralysis or numbness of face, arm or leg, or blurred vision in one or both eyes.
Insertion of NG or PEG tube placement, or replacement with multiple reassessments	
Irrigation of eye with Morgan lens	
Irrigation of bladder with 3-way foley catheter	
Sexual assault exam with specimen collection	
Psychotic patient – not suicidal	
Change trach tube	
EKG x 2 or more	
Care of a confused, combative patient	
Change in mental status of patient	

CPT® 99285/HCPCS® G0384 High Complexity	
The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. Multiple prescription medications and/or home therapies with review of side effects and potential adverse reactions; diabetic, seizure or asthma teaching in compromised or non-compliant patients; patient/caregiver may demonstrate difficulty understanding instructions and may require additional directions to support compliance with prescribed treatment.	
Procedure Examples	Clinical Examples
Cardiac monitoring	Chest pain – Cardiac
Multiple IVS	Active GI bleed – excluding fissure and hemorrhoid
Admit to ICU	Severe respiratory distress
Suicide watch	Epistaxis (complex)
Physical or chemical restraints	Blunt/penetrating trauma with multiple diagnostic testing
Coordination of Hospital admission, transfer or change in living situation or site	Systemic multi-system medical emergency requiring multiple diagnostics
Fracture reduction or relocation	Severe infections requiring IV/IM antibiotics
Endotracheal or trach tube insertion	Uncontrolled diabetes – Blood sugar level at 300 or higher and exhibiting complications like DKA and or unstable vital signs or HHNK
Endoscopy	Severe burns - (Level 3 or 4)
Thoracentesis or paracentesis	Hypothermia
Conscious sedation	New onset altered mental status
Decontamination for isolation, hazardous material	Headache (severe) requiring CT and/or Lumbar puncture

CPT® 99285/HCPCS® G0384 High Complexity	
The presented problem(s) are of high severity and pose an *immediate significant threat* to life or physiologic function. Multiple prescription medications and/or home therapies with review of side effects and potential adverse reactions; diabetic, seizure or asthma teaching in compromised or non-compliant patients; patient/caregiver may demonstrate difficulty understanding instructions and may require additional directions to support compliance with prescribed treatment.	
Procedure Examples	Clinical Examples
Precipitous delivery in ER	Major musculoskeletal injury
	Acute peripheral vascular compromise of extremities
	Toxic ingestions
	Suicidal or homicidal

Implants

Implants are objects or materials, which are implanted, such as a piece of tissue, a tooth, a pellet of medicine, a medical device, a tube, a graft, or an insert, placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life. Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to non-soluble or solid plastic materials used to augment tissues or to fill in areas traumatically or surgically removed. Instruments that are designed to be removed or discarded during the same operative session during which they are placed in the body are not implants. In addition to meeting the above criteria, implants must also remain in the Member's body upon discharge from the inpatient stay or outpatient procedure. Staples, sutures, clips, as well as temporary drains, tubes, and similar temporary medical devices shall not be considered implants.

Facility shall not bill Anthem for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member. Additionally, Anthem will not reimburse Facility for implants that are deemed contaminated and/or considered waste and/or were not implanted in the Member.

Observation Services

Anthem considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute Facility on that Facility's premises that includes the use of a bed and monitoring by that acute Facility's nursing or other staff and are required to observe a patient's condition to determine if the patient requires an inpatient admission to the Facility. Observation services include services provided to a patient designated as "observation status," and in general, shall not exceed

24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

- Active care or further observation is needed following emergency room care to determine if the patient is stabilized.
- The patient has a complication from an outpatient surgical procedure that requires additional recovery time that exceeds the normal recovery time.
- The patient care required is initially at or near the inpatient level; however, such care is expected to last less than a 24-hour timeframe.
- The patient requires further diagnostic testing and/or observation to make a diagnosis and establish appropriate treatment protocol.
- The patient requires short-term medical intervention of Facility staff, which requires the direction of a physician.
- The patient requires observation in order to determine if the patient requires admission into the Facility.

The payment, if any, for observation services is specified in the Plan Compensation Schedule or Provider Agreement with Facility. The language above is not intended to modify the terms and conditions of the Facility's agreement with the health plan. If Facility's agreement with Anthem does not provide for separate reimbursement for observation services, then this observation services language is not intended to, and shall not be construed to, allow the Facility to separately bill for and seek reimbursement for observation services.

The patient's medical record documentation for observation status must include a written order by the physician or other individual authorized by state licensure law and Facility staff bylaws to admit patients to the Facility that clearly states "admit to observation." Additionally, such documentation shall demonstrate that observation services are required by stating the specific problem, the treatment and/or frequency of the skilled service expected to be provided."

The following situations are examples of services that are considered by Anthem to be inappropriate use of observation services:

- Physician, patient, and/or family convenience
- Routine preparation and recovery for diagnostic or surgical procedures
- Social issues
- Blood administration
- Cases routinely cared for in the Emergency Room or Outpatient Department
- Routine recovery and postoperative care after outpatient surgery
- Standing orders following outpatient surgery
- Observation following an uncomplicated treatment or procedure

Preventable Adverse Events (PAE)

Acute Care General Hospitals

Three (3) Major Surgical Never Events

When any of the Preventable Adverse Events (PAEs) set forth in the grid below occur with respect to a Member, the acute care general Hospital shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan or the Member for such events. If acute care general Hospital receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general Hospital shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, acute care general Hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission (TJC), or a patient safety organization (PSO) certified and listed by the Agency for Healthcare Research and Quality (AHRQ).

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

CMS Hospital Acquired Conditions (HAC)

Anthem follows CMS' current and future recognition of HACs. Current and valid POA indicators (as defined by CMS) must be populated on all inpatient acute care Facility Claims.

When a HAC does occur, all inpatient acute care Facilities shall identify the charges and/or days which are the direct result of the HAC. Such charges and/or days shall be removed from the Claim prior to submitting to Anthem for payment. In no event shall the charges or days associated with the HAC be billed to either Anthem or the Member.

All Other Facilities (excluding Non-Acute Care General Hospitals)

Four (4) Major Surgical Never Events

When any of the PAEs set forth in the grid below occur with respect to a Member, the Facility shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan or the Member for such events. If Facility receives any payment from the Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Facilities shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Member, Facilities are encouraged to report the PAE to the appropriate state agency, TJC, or a PSO certified and listed by the AHRQ.

Preventable Adverse Event	Definition / Details
1. Surgery Performed on the Wrong Body Part	Any surgery performed on a body part that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
2. Surgery Performed on the Wrong Patient	Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient	Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
4. Retention of a foreign object in a patient after surgery or other procedure	Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.

Robotic Assisted Surgery

Robotic Assisted Surgery is defined as the performance of operative procedures with the assistance of robotic technology.

Anthem considers the use of robotic technology to be a technique that is integral to the primary surgery being performed and, therefore, not eligible for separate reimbursement. When billed, there will be no additional payment for charges associated with robotic technology.

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

Place of Service and Evaluation & Management Facility Reimbursement Policy

Description

This provision describes Anthem's policy regarding Facility reimbursement for services provided outside of the primary structure on the campus of a hospital or institutional Provider and for Evaluation & Management (E&M) services provided within the primary structure on the campus of a Hospital or institutional Provider.

The primary structure on the campus of a Hospital or an institutional Provider is the physical site location where there are state licensed inpatient beds and/or a state licensed emergency room or emergency department, as well as provision of 24 hours per day seven days a week on site continuous physician and nursing services for diagnosis and treatment of patients.

E&M services are defined as professional services rendered by a physician or other qualified health care professional for the prevention or diagnosis and treatment of illness or injury and the promotion of optimal health. E&M services typically include development of medical history, physical examination, medical decision making or counseling and coordination of care.

Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a Hospital or an institutional Provider, other than the primary structure on the campus of the Hospital or institutional Provider, or rented by a professional from the Hospital or an institutional Provider, must be billed on a *CMS-1500 Claim* form and are not reimbursable if they are billed on a *UB-04 Claim* form.
- Anthem shall not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a *UB-04 Claim* form.
- Anthem does not reimburse for professional E&M charges billed on a *UB-04 Claim* form regardless of where services are rendered; reimbursement for these charges are included in the professional fee allowance.
- All professional services including, but not limited to, those rendered by Hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, physical therapists, occupational therapists, speech therapists, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a *CMS-1500 Claim* form using the appropriate CPT®/HCPCS codes.
- Services rendered outside of the primary structure on the campus of a Hospital or an institutional Provider shall not be billed or reimbursed on a *UB-04 Claim* form. The Member is not responsible for these charges. Examples of Revenue Codes under which such services shall not be billed or reimbursed include, but are not limited to, the following groupings:

  0280 – 0289 Oncology Clinic

  0300 – 0309 Laboratory

0300 – 0319 Laboratory Pathological

0320 – 0329 Radiology Diagnostic

0330 – 0339 Radiology – Therapeutic and/or Chemotherapy Administration

0340 – 0349 Nuclear Medicine

0350 – 0359 CT Scan

0420 – 0429 Physical Therapy

0430 – 0439 Occupational Therapy

0440 – 0449 Speech Therapy

0481 – 0489 Cardiology Clinic

0510 – 0519 Clinic

0520 – 0529 Free Standing Clinic

0530 – 0539 Osteopathic Services

0540 – 0549 Ambulance

0610 – 0619 Magnetic Resonance Technology

0630 – 0637 Pharmacy

0740 – 0749 Sleep Study

0760 – 0769 Treatment or Observation Room

0770 – 0779 Preventive Care Codes

0780 – 0789 Telemedicine

0960 – 0989 Professional Fees

Professional E&M services shall not be billed or reimbursed on a *UB-04 Claim* form. The Member is not responsible for these charges.

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
53X – Osteopathic services
61X – MRI
62X – Medical/surgical supplies, incident to radiology or other services
73X – EKG/ECG
74X – EEG
92X – Other diagnostic services

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

Unless your Agreement with Anthem specifies a different timeframe, pre-admission/pre-surgical/ preoperative testing that occurs within seven (7) days prior to the inpatient admission or outpatient procedure will be included in the DRG Rate, Per Diem Rate, Case Rate or any other Anthem Rate for Covered Services, and shall not be billed or paid separately.

Remittance Advice

The Anthem Remittance Advice (RA) is a reimbursement report that consists of detailed line information and a payment summary. RAs are either issued electronically or as an Acrobat Reader pdf version from the Anthem claim processing system. The Online Provider Remit pdf document can be viewed and downloaded from ProviderAccess®.

- http://www.anthem.com/ca/provider/f0/s0/t0/pw_b132436.pdf?refer=provider

! IMPORTANT UPDATE ON PROVIDERACCESS®: Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will be moved to the Availity Web Portal (Availity).

All eligible payments to Hospitals and other Facilities are accumulated on the same issue date for paper-generated RAs. The resulting check represents benefits paid for many patients, service dates and claims.

Due to technical limitations, RAs may sometimes appear to vary from the terms of the Agreement. In such instances, the Agreement takes precedence.

ERA/EFT

The Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT) are available for Anthem commercial business through our Electronic Data Interchange (EDI) department. The ERA reduces administrative costs, increases control and minimizes reconciliation time.

For information regarding ERAs and EFTs, contact Anthem EDI Solutions at the toll-free phone number 1-800-470-9630.

How to Read the Remittance Advice

Refer to the *Exhibits* section *Remittance Advice Field Descriptions* for the Detailed Line Item Format.

Note: As of September 1, 2003, Federal Employee Program (FEP) *Remittance Advices* have been the same *Remittance Advices* used for the rest of Anthem. For information specific to Federal Employee Programs (FEP) refer to the *Federal Employees Health Benefits Program* section of this Manual.

3D Rendering of Imaging Studies Facility Reimbursement Policy

Description

Three-dimensional (3D) rendering of imaging studies uses multiple thin sections of images and reconstructs them into 3D images, which can extract and display anomalies and/or structures to optimize visualization of the pathology. This type of reconstruction may be applied to computed tomography (CT), magnetic resonance imaging (MRI), positron emission tomography (PET), other tomographic studies, or ultrasound (U/S) studies.

3D image reconstructions are rendered post-processing of the initial images under concurrent physician supervision. The reconstructions may take place either on the same scanner the original studies were conducted, which has 3D reconstruction built into the imaging software [Current Procedural Terminology (CPT®) code 76376] or on an independent workstation at a later time (CPT code 76377).

This policy documents the Health Plan's reimbursement position on 3D rendering of imaging studies.

Policy

The Health Plan considers 3D rendering of imaging studies to be included in the reimbursement for the imaging study performed. The Health Plan considers 3D rendering of imaging studies to be a technology and technique improvement, enabling computer generated real-time interaction with the image volume dataset. Therefore, separate visual enhancements reported with CPT codes 76376 and 76377 are not eligible for separate or additional reimbursement even when billed with modifier -59.

CPT is a registered trade mark of the American Medical Association

Coding

76376 – 3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound or other tomographic modality; not requiring image post-processing on an independent workstation.

76377 – requiring image post-processing on an independent workstation.

Use of Reimbursement Policy:

This policy is subject to federal and state laws, to the extent applicable, as well as the terms, conditions, and limitations of a Member's benefits. Reimbursement Policy is constantly evolving and we reserve the right to review and update these policies periodically.

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Medical Policy

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Medical Policy Formation

The Anthem Medical Policy Subcommittee (MPS) of the Physician Relations Committee (PRC) is the authorizing body for Anthem medical policy and clinical Utilization Management (UM) guidelines, which serve as a basis for coverage decisions. The MPS uses the resources of the Office of Medical Policy & Technology Assessment (OMPTA) and the Medical Policy & Technology Assessment Committee (MPTAC) in the review of medical policy and clinical UM guidelines. The principal component of the process is the review for development of medical necessity and/or investigational policy position statements or clinical indications for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services include, but are not limited to, devices, biologics and specialty pharmaceuticals, and behavioral health services.

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

The MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. The medical policies and clinical UM guidelines approved at MPTAC meetings are then further reviewed by the Anthem Medical Policy Subcommittee (MPS) of the Physicians Relations Committee (PRC). The MPTAC approved medical policy position statements that are approved by the MPS are implemented in California (see below regarding clinical UM guidelines). The MPTAC approved medical policy position statements that are not approved by the MPS are not implemented in California. MPS and MPTAC voting members and subcommittee members are required to disclose any potential conflicts of interest. In the event that a member discloses a conflict of interest, the associated member will not participate in the vote specific to the proposed relevant Medical Policy.

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

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

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

- electronic literature searches, which are conducted and collated; results are provided to the committee members;
- independent technology evaluation programs and materials published by professional associations, such as:
    - Blue Cross Blue Shield Association (BCBSA);
    - technology assessment entities;
    - appropriate government regulatory bodies; and
    - National physician specialty societies and associations.

The committee(s) may also consider the service/procedure being reviewed as a standard of care in the medical community with supporting documentation.

Additionally, for topics deemed to represent a significant change, or as otherwise required by law or accreditation, the medical policy team seeks additional input from selected experienced clinicians. This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States. These individuals are board certified Providers who are identified either with the assistance of an appropriate professional medical specialty society, by activity in a participating academic medical center or by participation in a corporate affiliated network. While the various professional medical societies may collaborate in this process through the provision of appropriate reviewers, the input received represents NEITHER an endorsement by the specialty society NOR an official position of the specialty society. MPTAC uses this information in the context of all other information presented from various sources.

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

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

All medical policies and clinical UM guidelines are publicly available on our website, which supports our efforts to provide greater transparency for Providers, Members and the public in general. To access these documents on the Anthem website, select “Medical Policies and Clinical UM Guidelines” under “Learn More” and select “Continue” after reading the disclaimer. The “By Category” page lists each category as a link at the top of the page. To view a specific category, choose the category link to be redirected. The “By Alpha” page lists all medical policies or clinical UM guidelines alphabetically by title. There is an alpha index at the top of the page. To find a title, select the appropriate letter to be redirected. Search functionality is also available.

The company also licenses and utilizes MCG® care guidelines and may also license and/or utilize the guidelines of other entities. These guidelines are also reviewed by the company’s MPS. Clinical UM guidelines that are approved by MPS may be implemented in California while clinical guidelines that are not approved by MPS will not be implemented in California.

Medical Policy and Clinical Utilization Management (UM) Guidelines Distinction

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the medical necessity of new technology and new applications of existing technology while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services.

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

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Introduction

This section addresses Utilization Management (UM) processes and the integration of Case Management (CM) services with Anthem Blue Cross (Anthem), UM is a process to assure the delivery of Medically Necessary, optimally achievable, quality patient care through appropriate utilization of resources in a cost effective and timely manner.

CM is a collaborative process of Member advocacy that evaluates, develops, implements, and coordinates options, resources and services. It includes working one-on-one with the Member and their families and other Members of the interdisciplinary care team, using behavioral change science to promote engagement. Members are empowered to exercise their options and access the services appropriate to meet their individual health needs using communication, education, and available resources to promote quality outcomes and optimize health care benefits.

Definitions

1. Behavioral Health Levels of Care. Anthem has defined five levels of care, which are listed below:
   - Acute Inpatient Hospitalization – Acute inpatient psychiatric hospitalization is defined as treatment in a Hospital psychiatric unit that includes 24-hour nursing and daily active treatment under the direction of a psychiatrist and certified by The Joint Commission (TJC) or the National Integrated Accreditation for Healthcare Organizations (NIAHO) as a Hospital. Acute psychiatric treatment is appropriate in an inpatient setting when required to stabilize Members who are in acute distress and return them to a level of functioning in which a lesser level of intense treatment can be provided. A need for acute inpatient care occurs when the Member requires 24-hour nursing care, close observation, assessment, treatment and a structured therapeutic environment that is available only in an acute inpatient setting.
   - Residential Treatment – Residential treatment is defined as specialized treatment that occurs in a residential treatment center. Licensure may differ somewhat by state, but these Facilities are typically designated residential, sub-acute, or intermediate care Facilities and may occur in care systems that provide multiple levels of care. Residential treatment is 24 hours per day and requires a minimum of one physician visit per week in a Facility-based setting. Wilderness programs are not considered residential treatment programs.
   - Partial Hospitalization – Partial hospitalization (sometimes called day treatment) is a structured, short-term treatment modality that offers nursing care and active treatment in a program that is operable at a minimum of six (6) hours per day, five (5) days per week. Members must attend a minimum of 6 hours per day when participating in a partial hospitalization program. Members are not cared for on a 24-hour per day basis, and typically leave the program each evening and/or weekends. Partial hospitalization treatment is provided by a multidisciplinary treatment team, which includes a psychiatrist. Partial hospitalization is an alternative to acute inpatient Hospital care and offers intensive, coordinated, multidisciplinary clinical services for Members that are able to function in the community at a minimally appropriate level and do not present an imminent potential for harm to themselves or others.
   - Intensive Outpatient Treatment – Intensive outpatient is a structured, short-term treatment modality that provides a combination of individual, group and family therapy. Intensive outpatient programs meet at least three times per week, providing a minimum of three (3) hours of treatment

per session. Intensive outpatient programs must be supervised by a licensed mental health professional. Intensive outpatient treatment is an alternative to inpatient or partial Hospital care and offers intensive, coordinated, multidisciplinary services for Members with an active psychiatric or substance related illness that are able to function in the community at a minimally appropriate level and present no imminent potential for harm to themselves or others.

- Outpatient Professional Treatment – Outpatient professional treatment is a level of care in which a mental health professional licensed to practice independently provides care to individuals in an outpatient setting, whether to the Member individually, in family therapy, or in a group modality. Traditional outpatient treatment ranges in time from medication management (e.g. 15 – 20 minutes) to 30 – 50 minutes or more for the psychotherapies.

Refer to the Anthem *BH Clinical UM* Guidelines for levels of care and intensity of services criteria. This is located at anthem.com/ca > scroll down to bottom of the page > Providers > Enter > Medical Policy, Clinical UM Guidelines (for Local Plan Members), Pre-Cert Requirements > Medical Policies and Clinical UM Guidelines > Behavioral Health Clinical UM Guidelines.

2. Behavioral Health Treatment. Professional services and treatment programs, including applied behavior analysis and evidence-based behavior intervention programs that develop or restore, to the maximum extent practicable, the functioning of an individual with autism spectrum disorder and that meets all of the following criteria:
   - The treatment is prescribed by a physician and surgeon licensed pursuant to Chapter 5 (commencing with Section 2000) of, or is developed by a psychologist licensed pursuant to Chapter 6.6 (commencing with Section 2900) of, Division 2 of the Business and Professions Code.
   - The treatment is provided under a treatment plan prescribed by a qualified autism service Provider and is administered by one of the following:
     - A qualified autism service Provider.
     - A qualified autism service professional supervised and employed by the qualified autism service Provider.
     - A qualified autism service paraprofessional supervised and employed by a qualified autism service Provider.
   - The treatment plan has measurable goals over a specific timeline that is developed and approved by the qualified autism service Provider for the specific patient being treated. The treatment plan shall be reviewed no less than once every six months by the qualified autism service Provider and modified whenever appropriate, and shall be consistent with Section 4686.2 of the Welfare and Institutions Code pursuant to which the qualified autism service Provider does all of the following:
     - Describes the patient's behavioral health impairments to be treated.
     - Designs an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the patient's progress is evaluated and reported.
     - Provides intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating pervasive developmental disorder or autism.
     - Discontinues intensive behavioral intervention services when the treatment goals and objectives are achieved or no longer appropriate.

- The treatment plan is not used for purposes of providing, or for the reimbursement of, respite, day care, or educational services and is not used to reimburse a parent for participating in the treatment program. The treatment plan shall be made available to the health care service plan upon request.

3. Business Day. Monday through Friday, excluding legal holidays.
4. Clinical Reviewer. Clinically experienced, licensed staff member who reviews and may approve medical care and services as medically appropriate using approved screening criteria and Anthem medical policy.
5. Continued Stay Review/Care Coordination Management. Review for medical necessity during service delivery, including review for transitions of care and discharge planning.
6. Facility-based Treatment. Services provided in a Facility vs. outpatient office setting for Mental Disorders, Chemical Dependency, and Detoxification. Included are general acute Hospital, psychiatric health Facility, chemical dependence recovery Hospital, residential treatment center or day treatment program center or other Facility-based treatment setting.
7. Notification. The telephonic and written communication to the health care professional(s) and the Member documenting the medical appropriateness decision, and informing the health care professional and Member of their rights if they disagree with the decision.
8. Peer Clinical Reviewer. A California licensed health care professional competent to evaluate the specific clinical aspects of the request specific to the medical condition, procedure and/or treatment under review.
9. Pre-service Review. Review for medical necessity prior to service delivery.
10. Post-service Review. Reviews for medical necessity after services have been rendered.
11. Qualified Autism Service Provider. Means either of the following:
    - A person, entity, or group that is certified by a national entity, such as the Behavior Analyst Certification Board, that is accredited by the National Commission for Certifying Agencies, and who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the person, entity or group that is nationally certified.
    - A person licensed as a physician and surgeon, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, who designs, supervises, or provides treatment for pervasive developmental disorder or autism, provided the services are within the experience and competence of the licensee.
12. Qualified autism service professional. An individual who meets all of the following criteria:
    - Provides behavioral health treatment.
    - Is employed and supervised by a qualified autism service Provider.
    - Provides treatment pursuant to a treatment plan developed and approved by the qualified autism service Provider.
    - Is a behavioral service Provider approved as a vendor by a California regional center to provide services as an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program as defined in Section

54342 of Title 17 of the California Code of Regulations.

- Has training and experience in providing services for pervasive developmental disorder or autism pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code.

13. Qualified autism service paraprofessional. An unlicensed and uncertified individual who meets all of the following criteria:
    - Is employed and supervised by a qualified autism service Provider.
    - Provides treatment and implements services pursuant to a treatment plan developed and approved by the qualified autism service Provider.
    - Meets the criteria set forth in the regulations adopted pursuant to Section 4686.3 of the Welfare and Institutions Code.
    - Has adequate education, training and experience, as certified by a qualified autism service Provider.
14. UM Intake Representative. Non-clinical staff who obtain non-clinical and structured clinical information, by telephone, at the time of the Member's request for review or service notification.
15. UM Reference Number. Unique number given to the health care professional(s) following review for medical necessity of a requested service specific to the Member. This number must be included on the claim for payment when services require review for medical necessity.

Utilization Management (UM)

UM Program

Providers and Facilities agree to abide by the following Utilization Management (UM) Program requirements. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below:

UM Program Overview

The Hospital must notify Anthem or the review organization of an admission or service within one business day of the day and time the Member is admitted or service is rendered. This notification can be provided by phone, FAX or electronic submission.

Hospitals have a contractual obligation to comply and cooperate with the Anthem UM program, including providing discharge and transition of care plans for Members.

Anthem's UM program may be administered either through an independent third party or through internal staff for the purpose of conducting UM, as provided in the Agreement. This document refers to both the third party contracting with Anthem and the internal Anthem staff conducting UM.

Anthem generally accepts approval decisions made by an independent review organization regarding medical necessity as binding. Denial decisions are subject to the procedures provided in the Agreement.

UM may be required when a service is requested or planned (pre-service review), during the course of care (continued stay review/care coordination management), or after services have been delivered (post-service 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 by the Provider during pre-service or continued stay review/care coordination management.
- The service is excluded from coverage.
- The Member is not eligible for coverage when the service is provided.

UM may be conducted via telephone, FAX, and electronic communication or by on-site clinical reviewers.

All inpatient medical admissions require UM (except inpatient Hospital stays for the routine delivery of a child or emergencies). UM for inpatient medical services may include, but is not limited to: acute hospitalizations, units described as sub-acute, step-down, Skilled Nursing Facility (SNF), designated skilled nursing bed/units, comprehensive outpatient rehabilitation Facilities, rehabilitation units, inpatient hospice, sub-acute rehabilitation Facilities or transitional living centers. These services are subject to admission review for medical necessity, service appropriateness and level of care. In addition, these services require approval from Anthem's UM program.

Non-inpatient medical services may require pre-service review. Anthem specific preauthorization requirements may be confirmed on the Anthem Provider website under the "Learn More" section, or by contacting customer service.

UM for behavioral health services, all levels of care require preauthorization except most outpatient professional services; there are still some outpatient professional services that require review after the 12th visit.

Pre-service Review

Provider shall ensure that non-emergency admissions and certain outpatient procedures as specified by plan are preauthorized. Provider shall provide the necessary demographic information and admitting diagnosis to Anthem UM within twenty-four (24) hours or next business day of a Member's admission for scheduled procedures. Facility shall notify the plan of admissions that result from emergency services within twenty-four (24) hours of the first business day following admission.

The pre-service review process begins with a request from the treating physician, physician's office staff, Hospital representative or Member prior to the planned admission or service. Requests for pre-service review will be accepted no greater than 90 days prior to planned service start date. If the service is requested via telephone, the Anthem Interactive Voice Response (IVR) prompts the caller to enter the subscriber's ID number. The IVR system routes the call to the appropriate UM department.

If the service requested by the Provider requires pre-service review, the intake representative obtains Member's demographic information, (including name, plan ID number, ordering physician information, place of service, type of service requested, applicable procedure codes and diagnosis codes), establishes the case online and forwards the case to the clinical reviewer. A clinical review is conducted utilizing approved screening criteria and/or Anthem Medical Policy/Clinical UM Guidelines. When the admission or service meets criteria, the admission or service is approved. For inpatient admissions, an initial length of stay is assigned. If the admission or service does meet criteria, refer to the peer clinical reviewer process later in this section.

When pre-service review is completed, the physician, Hospital, Facility, or other health care professional(s) and Member are notified in writing of the UM reference number, the specific services and dates approved as medical necessity.

*Emergency Behavioral Health/detoxification admissions do not require pre-service review. Refer to Continued Stay Review/Care Coordination Management subsection below.

Continued Stay Review/Care Coordination Management

Facility shall comply with all requests for medical information for continued stay review required to complete plan's review and discharge planning coordination. To facilitate the review process, Facility shall provide requested information within twenty-four (24) hours or one (1) business day of request. Continued stay review/care coordination management may occur by telephone, FAX, electronic communication or on-site clinical review.

The clinical reviewer will assess the clinical information submitted for severity of illness and intensity of service and certifies the appropriate level of care when criteria are met. If the admission or service does not meet criteria, refer to the peer clinical reviewer process later in this section. The process continues until the Member is discharged, or until inpatient care is no longer authorized. Continued stay review will be conducted on all pre-certified admissions that exceed the initial pre-certified length of stay. The Facility is required to notify Anthem and submit relevant clinical information.

The clinical reviewer coordinates with the physician, Hospital, Facility or other health care professional to address discharge planning and transition of care needs.

During the continued stay review/care coordination process, the physician, Hospital, Facility, or other health care professional is notified by telephone, FAX or electronic messaging of the review decision, including level of care and the UM reference number.

When the process is completed, the physician, Hospital, Facility or other health care professional(s) and Member are notified in writing of the UM reference number, the specific services and dates approved, as Medically Necessary.

On-site Continued Stay Review Program

As part of the UM program, Anthem maintains an On-site Continued Stay Review Program. The Facility UM staff is responsible for following the Member's stay and documenting the prescribed plan of treatment, promoting the efficient use of service and resources, and facilitating available alternative outpatient treatment options. The Facility agrees to cooperate with Anthem and provide Anthem with access to Members medical records as well as access to the Members when mutually agreed upon in performing on-site continued stay review and discharge planning related to, but not limited to, the following:

- Emergency inpatient admissions
- Pre-approved inpatient services
- Pre-approved focused procedure review services
- Case management referrals

Observation Bed Policy

Refer to the "Observation Services Policy" located in the *Reimbursement Policies* section of the Manual.

Post-service Review

Post-service (retrospective) UM review is designed to retrospectively review claims for health services in accordance with the Member's Health Benefit Plan and Anthem medical policy and clinical guidelines Medical records and pertinent information regarding the Member's care are reviewed by nurses (with input by physician consultants when necessary) against available benefits to determine the level of coverage for the claim, if any. This review may consider such factors as the medical necessity of services provided, whether the claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

Peer Clinical Review

If the clinical information submitted does not meet the clinical screening criteria, the service request will be referred by the clinical reviewer to an Anthem peer clinical reviewer. For pre-service requests, the Anthem peer clinical reviewer may attempt to contact the treating/ordering physician to obtain additional relevant clinical information, when appropriate. For continued stay review/care coordination requests, the Anthem peer clinical reviewer will attempt to contact the treating/ordering physician to obtain the relevant clinical information. For retrospective requests, clinical determination by the Anthem PCR will be based solely on the clinical information submitted.

The peer clinical reviewer will take into account any specific needs of the Member or characteristics of the local delivery system when reviewing the requested service. The service request will be denied if the peer clinical reviewer determines that the clinical information does not meet the screening criteria. If an adverse determination is made, the requesting physician or other health care professional is given the option of filing an appeal. Only a peer clinical reviewer (PCR) may render an adverse determination.

When the review is completed, the physician, Hospital, Facility, or other health care professional(s) and the Member are notified in writing of the Anthem peer clinical review determination.

Reversals

Utilization Management determinations may be reversed if

- New information is received that is relevant to an adverse determination, which was not available at the time of the determination, or;
- The original information provided to support a favorable determination was incorrect, fraudulent, or misleading

Peer to Peer

Anthem uses a clinical peer-to-peer review process by which our internal peer clinical reviewers (PCRs) re-examine cases when an adverse determination is made regarding health care services for Members. This process allows attending, treating or ordering physicians to request a peer-to-peer review to offer additional information and further discuss their cases with our PCR who made the initial adverse determination.

- Initiating a Peer-to-Peer Request: Providers can initiate a peer-to-peer request IF he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse determination is made. In compliance with nationally recognized guidelines from the NCQA and URAC, Provider 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.

For information regarding Medical Policy Formation, refer to the *Medical Policy* section of this Manual.

For review of the appeals process, refer to the *Member Grievance and Appeal Process* section of this Manual.

Failure to Comply With Utilization Management Program

Provider and Facility acknowledge that the Plan 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-service Review on specified outpatient procedures, as required under this Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs.

Utilization Review Timeframes

Urgent pre-service review decisions are made and communicated within 72 hours of receipt of the request.

Non-urgent pre-service review decisions are made within five business days of receipt of request. Decisions are communicated verbally to the requesting Provider within 24 hours of the decision and in writing to Members, physicians, Hospital, Facilities or other health care professionals within two business days of the decision.

Post-service review decisions are made and communicated in writing to the Member and the physician, Hospital, Facility, or other health care professional within 30 calendar days of receipt of the request.

If a decision on non-urgent pre-service review and post-service review cases cannot be made within the specified timeframe, due to insufficient information, the Member and physician, Hospital, Facility or other health care professional are notified in writing of the decision timeframe extension. This is called a “Pend” letter and the notification includes:

- The reason for decision timeframe extension
- The specific information required to complete the review
- The timeframe to submit the specific information required
- The timeframe for a decision, once the necessary medical information is obtained

When any information is received, this stops the Pend timeline and a decision needs to be rendered within the appropriate regulatory timelines.

Initial inpatient stay/care coordination review requests

When *sufficient clinical information has been submitted* with the request, the decision is made and communicated to the requesting physician, Hospital, Facility, or other health care professional by phone/FAX and written notification within 24 hours of receipt of the request.

When *sufficient clinical information has not been submitted* with the request, and additional clinical information has been requested by Anthem within 24 hours by Anthem, the timeframe can be extended to a maximum of 72 hours.

Additional/extension inpatient stay/care coordination review requests

Decisions and verbal/written communication regarding additional/extension stay authorization requests *received 24 hours prior to the last authorized day*, will be rendered within 24 hours of receipt of request.

Decisions and verbal/written communication regarding additional/extension stay authorization requests *received the day of, or after the last authorized day*, will be rendered within 72 hours of receipt of request.

Behavioral Health Review

Pre-service, continued stay review/care coordination management and post-service review processes are performed in the same manner as indicated in the above Utilization Management section.

Go to anthem.com/ca website to view the specific Behavioral Health Clinical UM Guidelines.

Parity Diagnosis and Benefits

Federal and state mental health parity legislation states that treatment of certain mental illnesses and serious emotional disturbances of a child will be covered on par with medical illnesses for participants within some types of health plans.

There is membership that is not currently governed by parity legislation. These Members continue to have coverage, but have variable benefit levels.

Prior to initiating treatment with a Member, you should always call the Anthem Customer Service unit to verify parity versus non-parity benefits.

Behavioral Health Follow-up Referrals

Anthem is committed to a Quality Improvement program in conjunction with Anthem contracted Facilities and professional Providers that encourages a follow-up appointment, with a lower level of care, within seven days after discharge from an acute psychiatric program. The goal of the program is to increase quality of care and decrease the likelihood of relapse or re-hospitalization.

The Anthem licensed clinicians, in conjunction with the Outreach Care Specialists Team works with Members and contracted Facilities and professional Providers to coordinate treatment with the goal of increasing the quality of patient care.

Facility quality management/discharge planning staff should expect telephone inquiries from the Anthem Blue Cross licensed clinicians and the Outreach Care Services Team. Contracted Facilities shall cooperate with requests from Anthem associates and provide the information necessary to ensure the highest quality of care possible. Contracted Facilities shall make best efforts to return telephone calls within one business day. Examples of required information are as follows:

- Patient Admit/Discharge Date
- Planned referral to Next Level of Care
- Confirmation of Referral Appointment – if available

Federal Employees Health Benefits Program

For information specific to Federal Employee Program (FEP), see section *Federal Employees Health Benefits Program* of this Manual.

Transplant

For information specific to transplant refer to section *Centers of Medical Excellence* and the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual*, which can be found in the *Exhibits* section.

BlueCard®

For information specific to BlueCard see section BlueCard® and the BlueCard Provider Manual, online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.

HMO and Other Direct Service Plans

For Members with HMO Benefit Agreements, Anthem delegates UM and data collection activities to the participating medical group (PMG) unless a Member is admitted to a Facility outside of the PMG/IPA contracted service area. All out of area requests for urgent care including Hospital admissions should be referred to Anthem for review. Only urgent or emergent care is covered outside the PMG/IPA service area by Anthem. The HMO contract requires Members to receive their medical services within their assigned PMG/IPA contracted service area. Anthem's responsibilities in the delegated system include assisting the PMGs/IPAs in developing and implementing their individual UM programs, and monitoring their compliance with regulatory standards.

Participating Medical Group Responsibility

The delegated participating medical group (PMG) for the HMO Member is responsible for authorizing all Hospital services for HMO Members. When admitting an Anthem HMO Member, contact the appropriate PMG for authorization using the telephone number on the back of the Member's health care identification (HCID) card. This telephone number is available 24 hours a day, seven days a week.

Each claim submitted for payment must have an authorization form from the Member's medical group attached. A Hospital that submits claims using electronic data entry must indicate the authorization number in the appropriate field of the data entry screen.

Decisions Related to Coverage or Service

Anthem requires that physicians and health care professionals make medical decisions based on Members' appropriateness of care and existence of coverage. Anthem does not reward practitioners or other individuals for issuing denials of coverage or service, and Anthem does not offer financial incentives to encourage decisions that result in underutilization.

Medicare Advantage

For information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook. Or, refer to the *Medicare Advantage* section of this Manual.

Electronic Data Exchange

Facility will make best effort to support Anthem with electronic data exchange with information such as, but not limited to, daily census and confirmed discharge dates.

Facility Electronic Census Feed

The Electronic Census Feed process was initiated as an alternative option for Facilities to electronically submit daily census files directly to a secured Anthem server to report inpatient admissions. All records received for a specific day will be verified via a confirmation report, which is sent from Anthem to the sending Facility via secured email to designated recipients.

The benefits of electronic census feed are as follows:

- Creates a path for automated notification and replaces cumbersome phone/FAX solutions
- Reduction of unreported days and retrospective review
- Early notification of inpatient admission generates bed day savings
- Ability to provide notification of inpatient admission seven days per week
- Auto routing of inpatient cases that exceed the authorized length of stay directly to Anthem clinical reviewer
- Enhances proactive and coordinated discharge planning and transition of care needs

Refer to the *Exhibits* section for the required data elements found in the *Facility Electronic Census Reporting File Feed Requirements* document.

Interactive Care Reviewer (ICR)

ICR offers a streamlined pre-certification and review process. It is available to Providers requesting inpatient and outpatient medical and behavioral health services* for many Members covered by Anthem. You can also locate information on a previously submitted request that was not submitted via ICR (e.g. via phone, FAX or electronic). You can access ICR through the Availity Web Portal at www.availity.com.

*Note: ICR is not available for all Anthem lines of business or all types of cases. Check the Availity Web Portal for details.

While ICR is used to request pre-certification or pre-service review for local Anthem Blue Cross Members, we also offer the same ability for out-of-state Members through the Availity Web Portal functionality called Electronic Provider Access (EPA). Enter specific Member information, and you're routed to the home plan of an out-of-state Member and from there, you can access the home plan's electronic pre-certification capabilities, if available.

UM Review for BlueCard® Members

For more information on UM requirements for BlueCard Members, refer to the BlueCard Provider Manual online at anthem.com/ca > scroll down to the bottom of the page select Providers > Enter > Communications > Blue Card® Program Provider Manual.

Out-of-network Referrals

Since the Member incurs higher copayments and deductibles when nonparticipating health care professionals and Facilities are used, every effort must be made to ensure referrals are made to participating health care professionals and Facilities.

When there are no Anthem in-network health care Providers available in the network supporting the Member's health benefit plan), the Member may request an out-of-network referral by calling the UM department toll-free number at 1-800-274-7767.

A UM clinical reviewer will review requests for out-of-network referrals. When an out-of-network referral is approved, the Member is covered at their higher in-network benefit level.

Access to Medical Policy

All medical policies and clinical UM guidelines are publicly available on the Anthem website.

Refer to the *Medical Policy* section of this Manual for more information on Medical Policy and Technology Assessment and the development and maintenance of Anthem medical policies.

Adverse Determinations and the Appeal Process

The *Member Grievance and Appeal Process* and *Dispute Resolution Process for Contracted Providers* sections of this Manual provide information regarding the process for addressing adverse determinations and appeals.

AIM® Specialty Health (formerly American Imaging Management®)

Since September 2008, AIM has administered Anthem's radiology benefits management program. AIM is an affiliate of Anthem and is a nationally recognized leader in advanced imaging management, with programs covering more than 35 million Members. AIM derives its clinical content from leading evidence-based guidelines and literature and has a strong reputation for promoting clinical excellence, innovation and Provider service. In addition, AIM's UM program is accredited by both URAC and the National Committee for Quality Assurance (NCQA). We will conduct the radiology benefits management program with AIM's valuable expertise and experience.

Ordering physicians must contact AIM to obtain a preauthorization for non-emergency outpatient advanced diagnostic imaging modalities including CT/CTA, MRI/MRA, Nuclear Cardiology and PET. Imaging studies performed in conjunction with emergency room services, inpatient hospitalization or rehabilitation, outpatient surgery (Hospitals and freestanding surgery centers), or 23-hour observations are excluded from this requirement. AIM reviews diagnostic imaging requests and does not review CTs and/or MRIs related to

biopsies or studies performed for treatment planning.

Note: Imaging Providers are strongly encouraged to verify that an authorization has been obtained before scheduling and performing diagnostic imaging exams.

Radiology Management Program – CPT Code List

A full list of the CPT codes included under this program can be found on Anthem's Provider portal, ProviderAccess at anthem.com/ca. Once you have logged in to ProviderAccess®, select the "AIM's Radiology Management Program" link. Then select the applicable "CPT Code List." The list may be updated from time to time to reflect changes published by the American Medical Association in the Current Procedural Terminology (CPT) Manual.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017. For more information and how to register on Availity, refer to the *Availity Web Portal (Availity)* section of this Manual

Ordering Physician Guidelines

Ordering physicians may contact AIM to initiate imaging requests through the following processes:

Internet Requests – Requests can be submitted online via AIM's web-based application *ProviderPortal*℠. AIM's *ProviderPortal* is available 24 hours a day, seven days a week. It is fully interactive, processing preauthorization service review requests in real-time using proprietary clinical criteria.

To access *ProviderPortal*, simply log in to Anthem's Provider portal, ProviderAccess, at anthem.com/ca > Providers.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017. For more information and how to register on Availity, refer to the *Availity Web Portal (Availity)* section of this Manual

Telephone Requests – Requests can be submitted to AIM via telephone. Providers can call the AIM toll-free phone number 1-877-291-0360, Monday through Friday, 7 am – 5 pm PST, to request a preauthorization service review reference number or to verify that a preauthorization service review reference number has been issued.

Required Information for Preauthorization Service Reviews

The checklist below is a guideline for ordering physicians to have all the information necessary prior to requesting a preauthorization service review:

- ✓ Member identification number, name, date of birth
- ✓ Ordering physician information (name, location)
- ✓ Imaging Provider information (name, location)
- ✓ Imaging exam(s) being requested (body part, right, left or bilateral)
- ✓ Patient diagnosis (suspected or confirmed)
- ✓ Clinical symptoms/indications (intensity/duration)

For most situations, the above will suffice. For complex cases, more information may be necessary, including:

- ✓ Results of past treatment history (previous tests, duration of previous therapy, relevant clinical medical history)

Based on clinical criteria, AIM will either issue a preauthorization-service review reference number or forward the case to a nurse or physician for review. The physician reviewer may contact the ordering physician to discuss the case in greater detail. Ordering physicians may also contact AIM's physician reviewer at any time during the preauthorization-service review process. Upon approval, AIM will provide the ordering physician with a preauthorization-service review reference number, which will be valid for 30 days from the date issued. Issuance of a preauthorization-service review reference number is not a guarantee of payment. When submitted, the claim will be processed in accordance with the terms of the Member's health benefit plan.

Note: Retrospective requests will not be considered.

Imaging Facility Guidelines

As a Provider of advanced imaging procedures that require preauthorization-service reviews, it is essential to develop a process to ensure that the appropriate authorization reference number(s) has been obtained.

To ensure that the pre-service review process is completed, do the following:

1. Communicate to all personnel involved in outpatient scheduling that a preauthorization-service review is required for the above-mentioned procedures.
2. If an ordering physician's office calls to schedule a patient for a procedure requiring a preauthorization-service review, request the authorization number from the ordering physician's office.
3. If the ordering physician's office has not requested a preauthorization-service review, inform that office of this requirement and advise it to call the AIM toll-free number at 1-877-291-0360, Monday through Friday, 7 am – 5 pm PST.
4. The rendering Facility can view authorizations online through Anthem's Provider portal, ProviderAccess, at anthem.com/ca > Providers. Select "Referrals & Pre-auths" and then select "Imaging and Specialty Drug Requests," which will take you to AIM's *ProviderPortal*. AIM's *ProviderPortal* is available 24 hours a day, seven days a week.

Note: Each procedure will require a separate authorization number.

If a patient calls to schedule an appointment for a procedure that requires a preauthorization-service review, and does not have the authorization reference number, that patient should be directed back to the physician who ordered the examination.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017. For more information and how to register on Availity, refer to the *Availity Web Portal (Availity)* section of this Manual.

Note:

Emergency room, observation and inpatient imaging procedures do not require pre-service review.

- It is the responsibility of the ordering physician to request a pre-service review.
- Providers rendering the previously-mentioned services should verify that an authorization number has been obtained.
- If you do not receive an authorization number, your claims for service may be denied.
- The issuance of an authorization number should not be construed to expand or alter the Member's covered benefits.

Outpatient Cardiac Diagnostic Imaging Modalities

Beginning with services provided on and after August 3, 2009, Anthem is requiring pre-notification for additional outpatient cardiac diagnostic imaging services, namely, stress echocardiography (SE), transesophageal echocardiography (TEE), and resting transthoracic echocardiography (TTE).
Newly added services will have a two-phase implementation process:

- Pre-notification – Notification and requested clinical information is required and medical necessity evaluation will be performed, resulting in a confirmation/tracking number. Servicing Providers' claims will not be denied as a result of the pre-notification process.
- Preauthorization – Notification and requested clinical information is required and preauthorization will be performed, resulting in the approval or denial of the requested services. Servicing Providers' claims will adjudicate based on the approval or denial outcome.

There is no change in the preauthorization process for existing diagnostic imaging services. Preauthorizations will continue to be performed with approval or denial decisions for these existing services.

Exam Results Captured for Advanced Diagnostic Cardiac Imaging Services

Anthem requests that either the ordering or servicing Provider office enters in the results of the study requested online. Two post-delivery questions will be asked, the same questions for every exam (including MPI, blood pool imaging/MUGA, echocardiography, as well as cardiac MRI, PET and CT/CTA):

- Categorize the exam results (choose one):
  - Normal
  - Abnormal (related to reason examination ordered)
  - Abnormal (unrelated to reason examination ordered)
  - Inconclusive
- Did this study conclude the investigation for the suspected diagnosis that prompted the test or was subsequent imaging required?
  - Concluded investigation
  - Subsequent imaging required

Reports categorizing this data will aid Anthem in their clinical review of cases.

On November 1, 2012, a new specialty benefit management program for home-based (unattended) diagnostic study and Facility-based (not inpatient) sleep testing and therapy services became effective. This new program considers the medical necessity of the sleep study as well as the clinical appropriateness of a Facility test or a test done in the home. Pre-certification is required for any subsequent treatment (therapy), both initial and ongoing. For therapy services, Members must meet usage criteria for the continued rental of equipment and replacement of supplies. This new program is administered by AIM and will include the following:

- Home sleep test (HST)
- In-lab sleep study (PSG)
- Titration study
- Initial treatment order (APAP, CPAP, BPAP and oral devices, appliances, and related supplies)
- Ongoing treatment order (APAP, CPAP, BPAP and oral devices, appliances, and related supplies)

Sleep Management Program

Effective November 1, 2012, the prior authorization requirement applies to Anthem Members who participate in Anthem Local and individual health plans, including HMO Members who are not enrolled with a PMG/IPA as well as HMO Members enrolled in the following PMG/IPAs: Scripps Clinic and Scripps Foundation, and The Industry Health Network. The requirement does not apply to the following Members:

- Those in the Federal Employee Program (FEP).
- Those for whom Anthem is secondary coverage, including those whose primary insurance carrier is Medicare.
- HMO Members, with the exception of those noted above.

In addition, verify prior authorization requirements for Members of other Blue Plans (BlueCard®) by going online and selecting the Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements box on the left-hand side of the Provider Home page at anthem.com/ca. You may also call the toll-free number 1-800-676-BLUE (2583).

AIM's Radiology and Sleep Management Programs and OptiNet®

Anthem is dedicated to helping meet the ever-changing needs of our customers and helping our Members optimize the value of their health care dollars. To support consumers looking for tools to guide them in making informed health care decisions, Anthem has gathered information about the imaging capabilities of all contracted Providers who perform certain advanced diagnostic imaging services and/or sleep study/test services. Through AIM's *OptiNet* online survey tool, we have collected data including training, imaging equipment, capacity, access and compliance with industry standards such as those established by The Joint Commission (TJC) (formerly JCAHO) and the American College of Radiology (ACR).

Anthem incorporated average cost information into *OptiNet*. Cost values are determined based on the allowed amount from up to 14 months of prior Claims for both professional and technical components. The average cost information for each advanced imaging modality grouper is presented. Both the information collected on the imaging and/or sleep capabilities of Anthem Providers, as well as the average cost values, has been made

available to Anthem physicians who request preauthorization for an advanced diagnostic imaging or sleep service via telephone or online.

When an ordering physician submits a preauthorization request online, a table highlighting the site scores and average cost information for the local imaging Providers will be provided. This table is only available in the Provider selection portion of the preauthorization process. In some instances, cost information will not be available. When this occurs, a dash will be displayed in the "$" column.

Note that any network imaging or sleep Provider may be selected to perform the requested imaging or sleep services. If the Member has out-of-network benefits, he or she may select a non-network Provider and those services will be subject to out-of-network benefit requirements and cost shares.

If you are a servicing Provider and have not completed your assessment online, log on to ProviderAccess, select the "Referrals & Pre-auths" tab, select the link for "Imaging and Specialty Drug Requests" and then select the option called "Access Your *OptiNet* Registration," select the option in the green box, "Access Your *OptiNet* Registration," then select the option "Begin Registration" located in the lower corner of the pop-up page.

Once on the AIM's ProviderPortal, a tutorial "How to Complete An *OptiNet* Registration" is available under "Reference Desk," then "Interactive/Tutorials."

If you have already completed your *OptiNet* assessment, you will be able to access your survey information, site score and cost information online, and update your information as appropriate.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017. For more information and how to register on Availity, refer to the *Availity Web Portal (Availity)* section of this Manual

Denial Process

Anthem has delegated AIM to perform UM on our behalf. This includes issuing denials.

Only AIM's PCRs (physicians) are able to render denials. Prior to rendering a denial, the AIM PCR will attempt to have a peer-to-peer discussion with the requesting ordering physician.

If a peer-to-peer discussion is successful, the AIM PCR will verbally communicate the denial and clinical rationale for the decision with the requesting ordering physician. Regardless of the success of the peer-to-peer discussion, AIM has a team that will attempt verbal notification of the denial and rationale for the determination. Following verbal notification, written correspondence will follow. The appeal process will be explained at the time of the denial.

Specific requirements can be found in the Member's EOC or obtained by calling the toll-free Customer Service number on the Member's HCID card.

Benefit levels and medical appropriateness review requirements differ significantly, depending on the Member's coverage, and are subject to change. So, physicians, Hospitals, Facilities or other health care professionals should use the "Eligibility and Benefit" link after logging into ProviderAccess at anthem.com/ca > Providers, to access Member-specific benefit information and plan-specific information regarding medical management requirements.

Anthem Specialty Drug Pre-service Medical Review Program

The Specialty Pharmacy Medical Management Department reviews for the medical necessity of specialty injectable or infusible medications that are covered under the Member's medical benefit. This program is an effort to speed up payments to Providers and help monitor Members' receipt and frequency of specialty drugs. *Prescription Drug Prior Authorization Request Form* and a list of specialty pharmaceuticals can be obtained by visiting anthem.com/ca > select **Medical Policy, Clinical UM Guidelines, and Pre-certification Requirements** or (see the *Links* section of this Manual). To obtain a pre-service medical review for a specialty pharmaceutical, call our Utilization Review department toll-free number at 1-800-274-7767, opt 4, or physicians may FAX the form to 1-866-408-7195 (toll free).

The Continuity of Care/Transition of Care Program for Members when their PMG, IPA, PPO Provider, or Hospital terminates from the Anthem Provider network and Newly Covered Enrollees*

*Exception: Members with an individual contract or a newly enrolled Member who had the option to continue with his/her other previous health plan or Provider and instead voluntarily chose to change health plans and their treating Provider is not part of the Anthem Provider network are not eligible.

The Transition Assistance Team 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. The goal of this process is to minimize service interruption and to coordinate a safe transition of care. Completion of Covered Services may be provided at an in-network rate with an out-of-network Provider for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider.

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

Members may request COC/TOC:

- If they are in an active course of treatment for an acute medical condition or a serious chronic condition. An acute medical condition is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. A serious chronic condition is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of Covered Services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider;
- If they are in an active course of treatment for any behavioral health condition;
- If they are pregnant, regardless of trimester;
- If they have a terminal illness;
- If they have a newborn child between the ages of birth and 36 months. Completion of Covered Services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another Provider;

- If they have a surgery or other procedure that has been authorized by the previous plan or its delegated Provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

Many Members are pleased to learn that their treating Providers already participate in one of our extensive networks and therefore no transition assistance is needed as they may continue treating with that Provider. Members may also call Customer Care to get assistance with the completion of this form over the phone and Customer Care will electronically submit the request to the Transition Assistance Department.

Requests for COC/TOC are made by completing the *Continuity of Care/Transition of Care Request Form* and faxing it along with a copy of the enrollment form directly to the Transition Assistance Department at 1-877-214-1781 toll free. Members may also call Customer Service to get assistance with the completion of this form over the phone and Customer Service will electronically submit the request to the Transition Assistance Department.

Following receipt of an application, Members will receive a telephonic acknowledgement from the Transition Assistance Team. The team will work with the Member and Provider to determine eligibility and care needs. A determination will be made within five (5) business days from the receipt of all information necessary to make a determination. Urgent requests will be decided within 72 hours from the receipt of all information necessary to make a determination. The Member will be notified of the determination by telephone and by mail.

If the Transition Assistance Team cannot approve the request for clinical or medical necessity reasons, the request is referred to a PCR for review. In addition to clinical denials, cases are referred to the PCR when the medical management nurse questions the appropriateness or quality of the Provider's treatment plan.

If the non-contracting Provider does not accept Anthem's in-network rate, no COC/TOC would be offered. Members would be financially responsible and may incur significant out-of-pocket expense if they choose to continue services with the non-contracting Provider.

If COC/TOC is approved, Members are covered at the in-network benefit level until treatment is concluded or until the Member can be safely transitioned to an Anthem network Provider; this will vary on a case-by-case basis.

Members in an active course of treatment for an acute phase or exacerbation of a serious chronic disease may be able to continue otherwise covered treatment with their non-contracted Provider at an in-network rate. Eligibility is determined by current clinical circumstances rather than a specific disease entity or diagnosis.

Members being treated for non-acute or chronic clinical conditions are usually not eligible for coverage of treatment by non-network Providers. If the Member requires ongoing care for any chronic condition and is not in an acute phase of their illness, one requiring a special course of treatment, the Member should select an in-network Provider to meet their ongoing health care needs and they do not need to request COC/TOC. If the Member needs assistance selecting a new Provider, they should contact Anthem Customer Service.

Members who do not meet COC/TOC criteria and choose to continue care with a Provider who is not in our network would be financially responsible and may incur significant out-of-pocket expense if they choose to continue services with the non-contracting Provider.

For a sample form, see the *Continuity of Care/Transition of Care Request Form* in the *Exhibits* section of this Manual these forms supersede all others used in the past).

Case Management

Overview

Anthem Case Managers and other health care professionals work closely with Members, families, and health care Providers to identify and address health care and coordination needs. The objectives of Anthem's Case Management (CM) services include a focus on reducing gaps in care, managing effective care transition issues, promoting Member's self-management plan of care, and supporting effective communication with the physician and Member's support system. To achieve the objectives, the Case Managers work in partnership with integrated teams including the Member, their caregivers as appropriate, physicians, case management medical directors, pharmacists, behavioral health case managers and others to support a Member-centric plan of care.

Identification of Cases

Anthem's CM services focus on the highest risk Members with a goal of improving their health and preventing readmissions. Anthem CM introduced a Readmission Predictive Modeling (RPM) process to our case identification processes. When Anthem is notified of an admission, the RPM methodology identifies and assigns a risk score to every Member admitted to an inpatient acute care Facility. The risk score is calculated using various data elements specific to the Member, but include inpatient and outpatient utilization history, pharmacy data, claims data, and Member demographics. Members meeting the established risk score criteria are referred to Case Management for outreach and engagement.

In addition to the RPM process, there are other methods by which Members are identified for case management. These include referrals from various sources (physicians, health care Providers, inter-departmental, employer group referrals) as well as Member/family referrals. Additional methods of identification involve clinical events, including, but not limited to:

- Hospital admissions with a length of stay 10 days or greater
- Three admissions for a Member within a rolling 12-month year
- High-risk pregnancies
- Neonatal Intensive Care Unit (NICU) admission
- Pediatric Members with complex needs
- Complex discharge planning coordination
- Bariatric CME mandates and bariatric surgery candidates
- Oncology, Hospice/End of Life care
- ELIZA, IVR supported technology, referrals including:
    - preadmission with 7-day prior notification
    - post discharge
    - high dollar claimant (greater than $75,000 of paid claims in a rolling 12-month period)
    - post case management graduation
    - oncology diagnoses

Program Enrollment and Member Engagement

Once a Member has been identified for potential CM, the Member is contacted for program enrollment. With Member acceptance of CM, a RN case manager performs an assessment of needs based on program parameters indicated above. The assessment process includes an assessment of physical, psychosocial, safety, functional status, knowledge, family and community support; availability of resources and benefits; and potential barriers to achieve optimal outcomes. The case manager contacts the Member, the family, involved health care service Providers, and the treating physician to collaboratively develop a Member-centric care plan, establish goals and implement interventions designed to meet Member goals. The initial and subsequent communication ensures that the Member understands their self-management plan of care, his/her significant others are involved in the Member's care and they are empowered to make decisions regarding their health care services. This communication supports a more complete and thorough assessment of the Member's needs and ensures the Member concerns or issues are addressed.

CM effectiveness increases with active participation and involvement of the Member or their representative. Opportunities to provide education to facilitate understanding of the disease process and avoid complications, understand medication regimens and treatment plans, involve community resources, and promote self-advocacy are more effective with active Member collaboration. If the Member declines participation, the case manager may work with the health care treatment team to monitor progress through the health care continuum. Case managers work with the Member to facilitate high-quality, cost-effective treatment plans and access whenever necessary. Case managers help identify quality Providers and vendors in the Member's area and are integral in helping coordinate the Member's care with multiple Providers. In addition, case managers, in collaboration with the treating physician, help identify gaps in care and transition Members to the appropriate levels of care as indicated. Case managers interact with medical directors when questions and issues arise or to discuss appropriate management of cases. CM medical directors are available to provide guidance on the management of a particular case or to facilitate communication with treating physicians or other Members of the health care team.

Cases are closed when goals are met, if the Member becomes ineligible for benefits, or the Member declines further participation in the CM program.

A Member (or Member's representative) may self-refer or a Provider may refer a Member to Anthem's Case Management team by calling the toll-free phone number 1-888-613-1130 or email to case.management@wellpoint.com.

Medicare Advantage

For information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook. Or, refer to the *Medicare Advantage* section of this Manual.

Condition Care (Disease Management)

As part of our Health and Wellness programs, Anthem offers ConditionCare, our disease management program. ConditionCare helps maximize Member health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult)
- Diabetes (pediatric and adult)
- Heart Failure (HF)
- Coronary Artery Disease (CAD)
- Chronic Obstructive Pulmonary Disease (COPD)

Employing proven technology, evidence-based practice guidelines and a team of experienced health care professionals, our award-winning ConditionCare program provides a strategy for all participants with gradations for risk level that allow us to reach more Members in our pool of eligible Members we identify. We track and monitor Member-specific interventions by creating an individualized care plan for each identified Member housed within our care management platform. We focus the most appropriate level and of evidence-based interventions in a timely manner to achieve successful and cost-effective management of the Member's condition.

The ConditionCare program further supports the physician/patient relationship and plan of care, and empowers Members to become more effective managers of their own health. Our condition-specific actionable materials reinforce program interventions and further assist Members with controlling their conditions.

A Total Management Approach

A total management approach is paramount to the success of the ConditionCare program. Through our primary nurse model, we achieve improved outcomes by focusing on our Members' overall health. We address all conditions and co-morbidities as they relate to and affect our Members' ability to manage their overall health.

We begin by having our team of Health Outreach Specialists (HOS) contact eligible Members we identify as most likely to benefit from ongoing one-on-one telephonic management and education from an assigned nurse coach. Calls to these moderate- and high-risk Members introduce the program, highlight its value and begin the enrollment process. The HOS team sets up next steps for Member participation including a follow-up call from the assigned nurse coach who conducts a comprehensive telephonic health assessment.

Our staff of health professionals includes registered nurses, pharmacists, registered dietitians, exercise physiologists, licensed social workers and medical directors.

We have received full accreditation from the National Committee for Quality Assurance (NCQA) for our ConditionCare programs addressing diabetes, asthma, CAD, HF and COPD. NCQA accreditation signifies that these programs have withstood an intense, comprehensive review in the areas of content, measurement and Quality Improvement, clinical systems, operation, and Member and practitioner service.

In addition, we offer our programs for kidney disease (chronic kidney disease and end-stage renal disease) partnership with an NCQA-accredited disease management company.

A Sophisticated Care Management System

Our care management platform, called the Healthy Returns System (HRS), ensures that Members receive consistent, individualized interventions based on the latest evidence-based clinical practice guidelines. The system enables our nurse coaches to effectively manage the entire Member. Our ConditionCare program addresses our Members' total health, which includes all conditions and co-morbidities as they relate to and affect their ability to manage their conditions.

The care management system collects Member-specific data in an electronic Health Chart. This dynamic medical record includes data associated with each Member's health, health care and the resulting care plan. The care management system supports our nurse coaches by:

- Tracking the Member's progress toward goals
- Providing a list of all care management resources available to the Member
- Allowing the flexibility to add new goals based on issues the Member identifies as important
- Giving nurses access to Member-specific health and benefit information

We continually incorporate new data into this dynamic process to ensure that Members successfully manage their conditions and health.

Advanced Predictive Stratification Models

Our ConditionCare program uses sophisticated predictive modeling to not only determine which Members of a population are statistically most at risk for future high cost, but also which Members we are most likely to impact by our ConditionCare interventions. Determining impactability is critical to identify Members that will most likely benefit from the intensive allocation of resources within a specific ConditionCare program.

Our predictive modeling tool incorporates clinical alert algorithms, diagnostic risk scores and statistical applications. We apply condition-specific models to deliver optimal results for Members we identify with specific conditions. In contrast, many competing statistical predictive models use a linear regression technique, and are more general in nature, which is more appropriate for pricing or underwriting, but is less appropriate for medical management purposes.

Identification

We analyze claims data to proactively identify and enroll eligible Members into the ConditionCare programs. This process encompasses the review of all available and relevant data:

- Medical claim and encounter data points (ICD-9 and CPT codes)
- Pharmacy claim data points (NDC codes)
- Ancillary data files (lab data, vision data)
- Health assessments
- Physician referrals
- Self referrals
- Complementary program referrals (e.g., 24/7 NurseLine and client EAP)
- Referrals from other Anthem resources (e.g., UM)

Stratification

Our customized predictive modeling process, known as AccuStrat, stratifies Members into the most appropriate outreach level. We analyze 100 percent of Members through our predictive modeling process on a monthly basis. We assign each Member risk scores indicating the likelihood of incurring future high costs including inpatient admissions. Our experience tells us that these are the key factors to identifying opportunities for optimizing financial returns and improving outcomes.

In addition, for clients that can provide lab values, we incorporate that important data stream into the predictive process, enhancing its efficacy.

We use predictive modeling results to effectively stratify and prioritize Member outreach, so that we can focus our resources to most effectively meet the needs of our Members. Additionally, our predictive modeling process flags

Member-specific opportunities, alerts, clinical indicators and lab data while automatically driving that information into a Member record available on the nurse desktop.

Enrollment

We employ an opt-out enrollment model. This means that we consider all eligible Members identified as having one or more of the chronic conditions addressed by our ConditionCare program as enrolled unless they decline participation. At the point of identification, we automatically register these Members into our system for ongoing management and tracking. It is our extensive experience that this strategy helps us maximize the number of Members we assist through the program.

Members we identify with one or more of our program conditions receive an initial welcome letter and care guide. It is at this point that the HOS team conducts a telephonic condition-specific health assessment to help determine the appropriate level (risk) of program interventions. Any eligible Member may also self-enroll into the ConditionCare program via our convenient 24-hour toll-free phone number.

The HOS team contacts Members who fall into our moderate- and high-risk stratification levels. These are Members we identify as most likely to benefit from ongoing one-on-one telephonic management and education from an assigned nurse coach because they are not meeting guideline recommendations for care and services. These Members receive more targeted messaging by mail and phone to encourage them to obtain necessary care and services for managing their condition. Our HOS team calls these Members to introduce the program, discuss its value, and begin the enrollment process. These calls also inform Members about ConditionCare program benefits.

The HOS team attempts up to four telephone contacts at three-day intervals to reach Members we identify as moderate or high risk. After the fourth call attempt, we mail a Get in Touch letter to the Member, and we also conduct telephone searches for all numbers we believe are invalid, incorrect or disconnected. If the HOS team does not reach a moderate- or high-risk Member by phone after four attempts, we continue to send the Member all applicable mailed media, such as quarterly condition-specific newsletters, and Therapeutic Alerts (participant-specific, guideline-based issues that generate alerts to address through ConditionCare program interventions). The HOS team will also continue attempting to re-engage Members if we continue to identify them through our predictive modeling process after a predetermined suppression time. This suppression timeframe depends upon the initial reason the Member is not currently enrolled (i.e., we did not reach the Member or they may have chosen to decline telephonic management).

Targeted Individualized Interventions

Our ConditionCare program focuses on providing Members with the most appropriate level and frequency of targeted individualized interventions. We engage eligible Members with introductory material that provides condition-specific education and demonstrates program value. For those requiring a higher level of management, we assign a nurse coach who works one-on-one with the Member to achieve the goal of reducing or stabilizing clinical severity and increasing management control over their condition. This consistency in relationship with a single primary nurse is an essential component of creating genuine change.

All ConditionCare program participants have access to the following resources:

- 24-Hour Inbound Calling.

  All enrolled Members have 24-hour access to experienced, registered nurses via a convenient toll-free phone number.
- Bilingual Nurses and Network Services Language Line.

Whether they speak Spanish, Swedish, Mandarin Chinese, or more than 100 other languages, Members can communicate with ease with a registered nurse via Network Services Language Line.

- Actionable Materials.

  Participants receive an initial educational packet that includes an introductory program cover letter, condition-specific care guide, and other helpful information such as our program's toll-free telephone number.
- Quarterly Newsletter.

  Asthma, diabetes, CAD, HF and COPD program participants receive a quarterly condition-specific newsletter that provides timely health news and helpful lifestyle and self-care information. The newsletter includes a feature article, common condition-related questions and answers, plus a resource listing. Additionally, it reminds Members about the convenient 24-hour toll free number for contacting our registered nurses.

Additional Effective Program Components

- Management of Co-morbidities. We address the impact and influence of co-morbid conditions by evaluating their presence during the initial Member assessment, and then on an ongoing basis.
- Pharmacy Counseling. Our pharmacists provide counseling and can speak simultaneously with our nurse coaches and either the Member or their physician. Our pharmacists complete a written pharmacy medication assessment. Provided to the Member, the Member's physician and the nurse coach, this information suggests methods of increasing medication adherence, plus highlights the potential effects of over-the-counter medications and supplements such as vitamins and herbal remedies.
- Nutritional Counseling. We employ full-time dietitians to address Member issues pertaining to diet and dietary management of their condition. Our dietitians instruct Members concerning food journaling, and conduct food histories to determine dietary adherence and barriers. They also counsel and assist Members with food selection while adhering to dietary parameters and conforming to financial or cultural constraints.
- Lifestyle Management Counseling. Members receive education and counseling concerning any lifestyle issues, such as smoking cessation or exercise, that impact the management and outcome of their conditions.
- Health Care Benefits Management. Nurse coaches discuss and, in some cases, may assist to coordinate appropriate client and/or vendor-approved Member benefits. Examples include home health services, mental health resources, dietitian consultation, condition-specific classes and cardio-pulmonary rehabilitation.
- Psychosocial Assessment. As part of our initial and ongoing assessments, we identify Members at risk for, or exhibiting signs and symptoms of, depression and/or the anxiety-related disorders that often accompany chronic disease and hinder treatment plan adherence. This assessment prompts the nurse coach to refer the Member to mental health resources for further assessment, diagnosis and counseling.
- Readiness and Motivation. We recognize that engendering behavior change among participants is fundamental to the ultimate effectiveness of any ConditionCare program. Therefore, the ConditionCare programs employ methodology from motivational interviewing strategies and other acclaimed models such as Dr. James Prochaska's *Readiness to Change* theories and the Health Belief Model. We seek to understand the Member's underlying confidence and the importance they perceive to make healthy lifestyle changes and further address barriers that may prevent these changes that can impact chronic conditions, such as a healthy diet, exercise and tobacco cessation.

- **Community Resource Referral.** We incorporate our clients' community health services organizations to maximize the resources available to assist Members. During the program implementation process, we collaborate with clients to obtain contact information for relevant community resources such as Meals on Wheels, and local government social and health service agencies.
- **Condition-Specific Actionable Materials.** All Members receive a condition-specific care guide featuring detailed information about the condition, etiologies and symptoms, related physiology, self-care techniques, medication adherence, lifestyle management, nutrition information and more.

Effective Provider Initiatives

A strong relationship with Providers is necessary to the success of our ConditionCare programs. An adjunct to physician care, the ConditionCare programs assist physicians by capturing and promoting their treatment plans. Physicians receive Member-specific feedback concerning adherence to their treatment plan, thereby keeping them more informed about their patient's health status and providing the opportunity to act.

We employ a full spectrum of effective initiatives to improve program awareness among treating physicians and encourage their feedback, collaboration and program advocacy. Through Provider engagement and feedback, our nurse coaches continually support and reinforce the prescribed treatment plan in every Member contact. We support physicians with individualized, actionable information and education concerning the latest standards of care. This collaboration allows for more productive patient encounters to drive better outcomes. The goals of our Provider strategies are:

- To improve Member health outcomes
- To improve adherence to evidence-based clinical guidelines

Current ConditionCare Programs

Asthma

Our ConditionCare program for asthma assigns nurse coaches to work closely with those Members identified as requiring ongoing one-on-one management and education. This strategy helps to minimize risk and improve outcomes by developing effective self-management regimens that include asthma trigger avoidance and medication adherence.

Monitoring Member adherence with our asthma program includes evaluating adherence to physician-prescribed medications and helping Members identify and manage potential asthma triggers within their environments. For asthma, we measure:

- Participation rates, specifically the percent of Member participation in our program
- Clinical measures of adherence to guideline recommendations
- Satisfaction, specifically Member and Provider satisfaction with our program
- Provider performance, specifically under-use of medication and adherence to guidelines

Outcome measures include:

- Health risk change using assessment tools
- Clinical outcomes, asthma control medication use, condition-related emergency room visits per 1000
- Functional status, specifically the impact of asthma on work and daily functionality
- Financial results, specifically return on investment (if available)

Diabetes

Diabetes management is complicated and often overwhelming. Our nurse coaches and supporting health professionals, including registered dietitians (many of which are certified diabetic educators) collaborate to help Members avoid health complications through effective lifestyle changes. Our program helps Members follow their treating physician's plan of care, undergo regular blood sugar testing, health screenings and observe a healthier diet. Monitoring compliance with the diabetes program includes evaluating the following Member data:

- Medication adherence
- Retinopathy screening
- Screening for A1c (blood sugar)
- Screening blood lipids
- Screening for blood pressure control
- Screening for kidney function
- Self-monitoring of blood glucose

Heart Failure (HF) and Coronary Artery Disease (CAD)

Adherence to the treating physician's plan of care for prescribed medications, diet and exercise can help Members with HF and/or CAD avoid the need for costly emergency room visits and Hospital admissions. Through helpful condition-specific education, our programs help Members become better self-managers of their condition and live fuller lives. Members in any of our ConditionCare programs have 24-hour toll-free access to experienced nurse coaches for questions about their condition and its management. Condition-specific program outcome measures include the evaluation of the following:

- Blood pressure control
- Emergency room visits
- Hospital admissions and average length of stay
- For CAD, screening for lipid testing and prescribed lipid lowering medication
- For HF, weight monitoring and adherence to a sodium restricted diet
- Use of prescribed ACE inhibitor medications
- Use of prescribed Beta Blocker medications

Chronic Obstructive Pulmonary Disease (COPD)

COPD often becomes more serious the longer a person has the condition. With our targeted COPD program, we can help to slow the condition's advance so that Members can live a more normal and healthier life. Through a convenient toll-free phone number, our program gives Members access to a staff of experienced registered nurses who are available to answer questions about how best to live more fully with COPD. We also have licensed pharmacists on staff to counsel Members about how to take their physician-prescribed medications for maximum effectiveness. If the Member is on oxygen therapy, our nurses are available to work with Members to adhere to therapy.

An assigned nurse coach provides ongoing telephonic management and education to Members requiring higher intensities of targeted care for their COPD. This nurse calls on a regular basis to help ensure appropriate management of the Member's condition. Our nurse coaches also help Members to understand the treating

physician's plan of care and collaborate as necessary with program pharmacists, dietitians, exercise physiologists and social workers to help achieve designated health goals.

You can contact the Health and Wellness ConditionCare Program at:

- 1-800-522-5560 (toll free) (Members of Fully-insured and FEP plans)
- 1-800-621-2232 (toll free) (Members of Self-insured Group plans)

Centers of Medical Excellence Program

The Anthem Centers of Medical Excellence (CME) program for certifying transplant Facilities ensures Members that all transplant centers meet strict clinical criteria and maintain high levels of service. Refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* in the *Exhibit* section of this Manual.

Anthem's oversight of CME Facilities may include on-site visits to each transplant center – to strengthen and maintain the managed care partnership. For better oversight of the transplant centers, CME Facilities are required to submit annual outcome data. Solid organ transplant programs will submit data using the current online version of the United Network for Organ Sharing (UNOS) standardized *Request for Information* (RFI) forms. Access to the secure data entry site can be obtained by contacting UNOS. Bone marrow/stem cell programs will submit data using the current American Society for Blood and Marrow Transplant (ASBMT) standardized RFI forms, which can be accessed at www.asbmt.org.

The information requested includes:

1. Medicare and Medicaid certification status, UNOS status (solid organ programs) and FACT Certification status (bone marrow/stem cell programs)
2. Number of patients who have received transplants by age, sex and disease type
3. Outcome statistics
4. Selection and exclusion criteria for all transplant procedures and protocols performed
5. Experimental protocols participation
6. Transplant team composition, experience and training background
7. Quality Improvement plans
8. Available support programs and educational opportunities for patients

The CME quality review process for participation in the CME network will include evaluation of selection criteria that encompass, but are not limited to, the following:

Solid Organ Transplant Programs:

- Volume (by transplant type)
- One-month, one-year, and three-year patient and graft survival
- Transplant rate
- Mortality while on the wait list rate
- Team composition and stability
- Percent of follow up

Bone Marrow/Stem Cell Transplant Programs:

- Volume (by transplant type)
- 100-day and one-year patient survival outcomes
- Percent of follow up
- CIBMTR data submission
- FACT accreditation
- Team composition and stability

Health care Facilities that are denied acceptance into the CME Transplant Program, or are terminated from the CME Transplant Program, will have access to the reconsideration or appeal process described in the *Legal and Administrative Requirements Overview* section of this Manual.

As a CME Facility, each center agrees to immediately report major changes in its team or program structures, or its federal rating status (such as loss of Medicare certification). All health care professionals are required to refer patients to a CME Facility, unless there is a medical reason for referring the patient to a non-CME Facility.

Enterprise Transplant and Bariatric Buy Up Department Program

The Enterprise Transplant and Bariatric Buy Up Department Program Case Management is comprised of specially trained nurses. These case managers specialize in the management of Members undergoing transplants, including heart, lung, heart/lung, liver, kidney, liver/kidney, pancreas, small bowel/intestinal, multi-visceral and stem cell/bone marrow, as well as other approved transplant procedures. Refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* located in the *Exhibits* section of this Manual.

Pre-certification Process for Transplants (HMO):

All transplant requests for commercial HMO Members must be directed to the Member's assigned Provider group.

If the HMO Member has a transplant benefit and is seeking services at an in-network Facility, the Provider group will review the transplant request and if approved, the Provider group is responsible for issuing the approval notification.

If the Provider group reviews the request and recommends a denial based on Anthem's Medical Policy, the request is pended for expert review and the supporting clinical information is forwarded to the Anthem Transplant Case Management Department.

If the Anthem Transplant Case Management Department recommends approval of the transplant, the Provider group is responsible for issuing the approval notification.

If the Anthem Transplant Case Management Department recommends denial of the transplant, Anthem Transplant Case Management department is responsible for issuing the denial notification.

If an HMO Member has a benefit limitation, the Provider group is responsible for issuing the denial notification.

If an HMO transplant request is seeking services to an out-of-network Facility, the Provider group will redirect the transplant services to an in-network Facility and is responsible for issuing the denial notification.

The HMO Member's Provider group is responsible for conducting UM continued stay review/care coordination and discharge planning once the Member is admitted for the transplant procedure.

Pre-certification and Admission Process for Transplants (PPO):

Pre-admission Review or Pre-transplant Review. This review determines whether a scheduled admission, transplant or transplant services are Medically Necessary. Such review is required for all non-emergent admissions and transplants. Any such requirement for admissions is indicated on the Member's HCID card.

Pre-service Review. This review determines whether the scheduled outpatient and ambulatory procedures are Medically Necessary. Services that may be subject to pre-service review include, but are not limited to, the following:

1. Pre-transplant evaluations and work-ups
2. Donor search and matching
3. Marrow/stem cell collection, modification or storage
4. Other pre-transplant and post-transplant services to be provided to the Member outside of the case-rate period, and rendered on an outpatient basis

Pre-certification is required for all organ and tissue transplant admissions. To begin the Member's recertification, a representative from the CME/Facility or the Member's physician calls the Anthem Enterprise Transplant and Bariatric Buy Up Department toll-free number at 1-888-574-7215.

After eligibility is established, the case is routed to a transplant case manager for initial assessment.

The transplant case manager reviews and determines the appropriateness of the diagnosis, the type of transplant requested, the referral for transplant, and the Member's eligibility. The Enterprise Transplant and Bariatric Buy Up Department Program may issue a Clinical Data Submission Tool to obtain necessary information to complete the review for medical necessity of the requested transplant. After the initial review, the transplant case manager contacts the CME/Facility, if additional clinical information is required and/or to authorize the requested procedure. Once medical necessity is established, authorization letters are sent to the transplant physician, CME/Facility and the Member.

When admission for transplant occurs, the CME/Facility contacts the assigned transplant case manager for ongoing case management.

Review Process

Recertification. For Members on the transplant waiting list, regular and ongoing updates and reviews are performed on a case-by-case basis and upon request from the CME/Facility. Benefits and eligibility will be checked and verified at these intervals. A written confirmation of the updated authorization, with the verification number, will be sent in the mail.

Continued Stay Review/Care Coordination. Determines whether a continued inpatient stay is Medically Necessary. Such review is required for all Members not discharged within the approved length of stay.

Retrospective Review. When pre-certification has not been performed and the transplant evaluation or procedure has been performed, a thorough review will be done by the Anthem Enterprise Transplant and Bariatric Buy Up Department to determine if services were Medically Necessary.

On-site Review. There is no On-site review for transplant.

Transplant Denials

In the event that a transplant request does not meet medical policy, the case is sent to an external review agency for independent specialty matched review. If the initial determination is denied, the physician and Member are contacted both verbally and in writing. Peer-to-peer consultations are offered to the treating physician by the medical director. Based on the Member's request for appeal, another physician advisor may review the case, or the case may be compiled and sent to an outside medical review agency for an impartial review and reconsideration for approval or denial.

The transplant case managers approve transplants for medical necessity only. Each transplant is reviewed prior to the procedure. The transplant medical director is responsible for transplant case management review procedures, and oversees all nurse review and CM activities.

In addition, the transplant case managers perform the following activities:

1. Evaluation, coordination, direction and ongoing review of the referred Member
2. Specialty care
3. Providing assistance for network development

You can contact the Enterprise Transplant and Bariatric Buy Up Department Program at:

Anthem Blue Cross
Enterprise Transplant and Bariatric Dept.
13550 Triton Park Blvd Mail Point: KY0304-A670
Louisville, KY 40223

Telephone number: 1-888-574-7215 (toll free)
FAX number: 1-877-264-4540 (toll free)

Additional Requirements

Audits/Records Requests

At any time, Anthem may request on-site, electronic or hard copy medical records, utilization review sheets 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.

Quality of Care Incident

Facilities will notify Anthem in the event there is a quality of care incident that involves a Member.

Utilization Statistics Information

On occasion, Anthem may request utilization statistics for disease management purposes using coded services identifiers. These may include but are not limited to:

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

This information will be provided by Facility to Anthem at no charge to Anthem.

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Credentialing Scope

Anthem credentials the following health care practitioners:

- medical doctors
- doctors of osteopathic medicine
- doctors of podiatry
- chiropractors
- optometrists providing Health Services covered under the Health Benefits Plan
- doctors of dentistry providing Health Services covered under the Health Benefits Plan including oral maxillofacial surgeons
- psychologists who are state certified or licensed and have doctoral or master's level training
- clinical social workers who are state certified or state licensed and have master's level training
- psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master's level training
- other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- telemedicine practitioners who have an independent relationship with Anthem and who provide treatment services under the Health Benefits Plan
- medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- licensed genetic counselors who are licensed by the state to practice independently
- audiologists who are licensed by the state to practice independently
- acupuncturists (non-medical doctors or doctors of osteopathic medicine) who are licensed, certified or registered by the state to practice independently
- nurse practitioners who are licensed, certified or registered by the state to practice independently
- certified nurse midwives who are licensed, certified or registered by the state to practice independently
- physician assistants (as required locally)

Anthem also certifies the following behavioral health practitioners (including verification of licensure by the applicable state licensing board to independently provide behavioral health services):

- certified behavioral analysts
- certified addiction counselors
- substance abuse practitioners

Anthem credentials the following Health Delivery Organizations (HDOs):

- Hospitals
- home health agencies
- skilled nursing facilities
- nursing homes

- free-standing surgical centers
- behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting, including:
    - adult family care/foster care homes
    - ambulatory detox
    - community mental health centers (CMHC)
    - crisis stabilization units
    - intensive family intervention services
    - intensive outpatient – mental health and/or substance abuse
    - methadone maintenance clinics
    - outpatient mental health clinics
    - outpatient substance abuse clinics
    - partial hospitalization – mental health and/or substance abuse
    - residential treatment centers (RTC) – psychiatric and/or substance abuse
- birthing centers
- convenient care centers/retail health clinics
- intermediate care facilities
- urgent care centers
- federally qualified health centers (FQHC)
- home infusion therapy agencies
- rural health clinics

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

- Clinical laboratories (a CMS-issued CLIA certificate or a hospital based exemption from CLIA)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities)
- Portable x-ray suppliers

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner's participation in a Network or Plan Program is conducted by a peer review body, known as Anthem's Credentials Committee (CC).

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no

more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant's participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes; and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Anthem, which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Anthem, which includes the letter, which initiates the credentialing process, the Provider website or Provider Manual. When such requests are received, Providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the Provider requests a written response.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and

rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its Networks or Plan Programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem's Networks or Plan Programs. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (CAQH), a Universal Credentialing Datasource is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their website at CAQH.org

Anthem will verify those elements related to an applicants' legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations • The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS

Verification Element
registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

Verification Element
Accreditation, if applicable
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Recredentialing

The recredentialing process incorporates re-verification and the identification of changes in the practitioner's or HDO's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) 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.

During the recredentialing process, Anthem will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of Anthem Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

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

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Chair of Anthem CC, review by the Anthem Medical Director, referral to the CC or termination. Anthem credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.

Appeals Process

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat Network practitioners and HDOs, as well as those applying for participation, fairly and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in Anthem's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (NPDB). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions, which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs and those denials of request for initial participation, which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner's or HDO's suspension or loss of licensure, criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participation poses an imminent risk of harm to Members. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered IndividualsMembers; and
C. Possess a current, valid, and unrestricted Drug Enforcement Agency (DEA) and/or Controlled Dangerous Substances (CDS) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members; the DEA/CDS registration must be valid in the

state(s) in which the practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs, and oral and maxillofacial surgeons, the applicant must have current, in force board certification [as defined by the American Board of Medical Specialties (ABMS), American Osteopathic Association (AOA), Royal College of Physicians and Surgeons of Canada (RCPSC), College of Family Physicians of Canada (CFPC), American Board of Podiatric Surgery (ABPS), American Board of Podiatric Medicine (ABPM), or American Board of Oral and Maxillofacial Surgery (ABOMS)] in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.

   1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
      a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which they are applying, which has now expired AND a minimum of ten (10) consecutive years of clinical practice. OR
      b. Training, which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
      c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Anthem's Network AND the applicant's professional activities are spent at that institution at least fifty percent (50%) of the time.
   2. Practitioners meeting one of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

B. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO), an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
   a. No evidence of potential material omission(s) on application;
      Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Members;
4. No current license action;
5. No history of licensing board action in any state;
6. No current federal sanction and no history of federal sanctions [per System for Award Management (SAM), OIG and OPM report nor on NPDB report];
7. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.

   Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:
   a. It can be verified that this application is pending.
   b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
   c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
   d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
      ii. Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating Members will be notified of the need to obtain the additional DEA/CDS registration. If the applicant has applied for additional DEA/CDS registration the credentialing process may proceed if ALL the following criteria are met:
         (a) It can be verified that this application is pending and,
         (b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained,
         (c) The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration,
         (d) Anthem will verify the appropriate DEA/CDS registration via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network, AND

(e) Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

8. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
9. No history of, or current use of, illegal drugs or history of or current alcoholism;
10. No impairment or other condition, which would negatively impact the ability to perform the essential functions in their professional field.
11. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two (2) years.
12. No history of criminal/felony convictions or a plea of no contest;
13. A minimum of the past ten (10) years of malpractice case history is reviewed.
14. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
15. No involuntary terminations from an HMO or PPO;
16. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
    a. investment or business interest in ancillary services, equipment or supplies;
    b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. voluntary surrender of state license related to relocation or nonuse of said license;
    d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
    e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
    g. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC

after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner's name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
   Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
3. No evidence of potential material omission(s) on re-credentialing application;
4. Currently participating Providers must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP. If, once a Practitioner participates in Anthem's programs or Provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or Provider Network(s) as well as Anthem's other credentialed Provider Network(s). Special consideration regarding the Practitioner's continued participation in Anthem's other credentialed practitioner Network(s) may be requested by the Vice President (VP) responsible for that Network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the Practitioner is important for network adequacy. The request with supporting information will be brought to Anthem's geographic Credentials Committee for consideration and final determination, without Practitioner appeal rights related to the special consideration, regarding the Practitioner's continued participation in Anthem's other credentialed Provider Network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Members;
6. *No current license probation;
7. *License is unencumbered;
8. No new history of licensing board reprimand since prior credentialing review;
9. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
10. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of, or current, restrictions;
11. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to needing hospitalization;
12. No new (since previous credentialing review) history of, or current use of, illegal drugs or alcoholism;
13. No impairment or other condition, which would negatively impact the ability to perform the

essential functions in their professional field;

14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
15. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
17. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:
    a. investment or business interest in ancillary services, equipment or supplies;
    b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
    c. voluntary surrender of state license related to relocation or nonuse of said license;
    d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
    e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no longer offering coverage in a state or no longer in business);
    f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
    g. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
    h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
18. No QI data or other performance data including complaints above the set threshold.
19. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers (LCSW) or other master level social work license type:
    a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (CSWE) or the Canadian Association on Social Work Education (CASWE).
    b. Program must have been accredited within three (3) years of the time the practitioner graduated.

   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the American Psychological Association (APA) or be regionally accredited by the Council for Higher Education Accreditation (CHEA). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
2. Licensed professional counselor (LPC) and marriage and family therapist (MFT) or other master level license type:
   a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (CACREP), or Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
   d. If master's level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. In addition, a doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (ANA) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
   d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (ABPN) or American Board of Clinical Neuropsychology (ABCN).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i Transcript of applicable pre-doctoral training, OR
      ii Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
      iii Letters from supervisors in clinical neuropsychology (including number of hours per week), OR
      iv Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week.
6. Licensed Psychoanalysts:
   a. Applies only to Practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting

agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.

a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

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

c) Meet examination requirements for licensure as determined by the licensing state.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review, which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every three (3) years to assess the HDO's continued compliance with Anthem standards.

A. General Criteria for HDOs:

1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's programs or Provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or Provider Network(s) as well as Anthem's other credentialed Provider Network(s). Special consideration regarding the HDO's continued participation in Anthem's other credentialed practitioner Network(s) may be requested by the Vice President (VP) responsible for that Network(s) if, in the opinion of the requesting VP, the following criteria are met: the federal sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the HDO is important for network adequacy. The request with supporting information will be brought to Anthem's geographic Credentials Committee for consideration and final determination, without HDO appeal rights related to the special consideration, regarding the HDO's continued participation in Anthem's other credentialed Provider Network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
4. Liability insurance acceptable to Anthem.

5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Medical Facilities

Facility Type (Medical Care)	Acceptable Accrediting Agencies
Acute Care Hospital	CIQH, CTEAM, HFAP, DNV/NIAHO, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC
Clinical Laboratories	CLIA, COLA
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA
Dialysis Center	TJC
Federally Qualified Health Center (FQHC)	AAAHC
Free-Standing Surgical Centers	AAAASF, AAPSF, HFAP, IMQ, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Hospice	ACHC, CHAP, TJC
Intermediate Care Facilities	CTEAM
Portable X-ray Suppliers	FDA Certification
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC
Rural Health Clinic (RHC)	AAAASF, CTEAM, TJC
Urgent Care Center (UCC)	AAAHC, IMQ, TJC, UCAOA

Behavioral Health

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Care Hospital – Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation	HFAP, NIAHO, TJC
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, DNV/NIAHO, TJC, COA, CARF
Outpatient Mental Health Clinic	HFAP, TJC, CARF, COA
Partial Hospitalization/Day Treatment – Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care Facility or Residential Treatment Facilities.
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	DNV/NIAHO, TJC, HFAP, CARF, COA

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, TJC
Outpatient Substance Abuse Clinics	CARF, COA, TJC

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Quality Improvement Program Overview

"Together, we are transforming health care with trusted and caring solutions." We believe health care is local and Anthem has a strong local presence required to understand and meet customer needs. Our Plan is well positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Our local Plan presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Providers and Facilities must cooperate with Quality Improvement activities. Our commitment to health improvement and care management provides added value to customers and health care professionals – helping improve both health and health care costs for those Anthem serves. Anthem takes a leadership role to improve the health of communities, and is helping to address some of health care's most pressing issues. The Quality improvement (QI) Program Description defines the quality infrastructure that supports Anthem's improvement strategies.

- The QI Program Description establishes QI Program governance, scope, goals, measurable objectives, structure and responsibilities, encompassing the quality of medical and behavioral health care and services provided to Members.
- Annually, a QI Work Plan is developed and implemented, which reflects ongoing progress made on QI activities during the year. The QI Work Plan includes the Plan's approach to patient safety, improving medical and behavioral health care: quality of clinical care, safety of clinical care, and quality of service.
- The QI Evaluation assesses outcomes of the Plan's medical and behavioral health programs, processes and activities. The QI Evaluation also evaluates how the QI Program goals and objectives were met.

To see a summary of Anthem's QI Program and most current outcomes, visit us online. Go to anthem.com/ca, and scroll to the bottom of the page, select the Providers > select Enter (under the "Welcome to Anthem Blue Cross"). On the Provider Home page, under the Health & Wellness tab (on the blue toolbar) select Quality Improvements and Standards, then the link titled Quality Improvement Program.

Goals and Objectives

The following QI Program goals and objectives have been adopted to support Anthem's vision and values and to promote continuous improvement in quality care, patient safety, and quality of service to Members, Providers, and Facilities.

- To develop and maintain a well-integrated system to continuously identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.
- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations, including compliance with regulatory requirements, accreditation standards, and policies and procedures.
- To promote processes that reduce medical errors and improve patient safety by implementing Member-focused, Provider/Provider initiatives, and safety initiatives identified by element-level activities.

- To identify the educational needs of Members, Providers, and other health care professionals including behavioral health practitioners and Providers.
- To identify health disparities trends for our eligible Members based on key clinical quality metrics evidence-based research, or Member experience metrics to inform response needs with appropriate culturally and linguistically enhanced services.
- To help maximize health status, improve health outcomes, and reduce health care costs of Members through effective Case Management and Disease Management programs addressing complex care needs.

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

Quality and Safety of Clinical Care

- Chronic Disease and Prevention: Anthem focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and COPD, and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set).
- Behavioral Health Case Management: A program designed to provide a comprehensive and integrated approach to early identification, appropriate treatment, intensive case management, and individualized recovery support for Members with complex, behavioral health conditions who are at risk for negative outcomes and high costs.
- Community Health: Addresses public health priorities including behavioral health, cancer, diabetes, maternal/child health, obesity, patient safety, and smoking cessation by collaborating with key stakeholders in the industry. These focus areas align with Anthem Foundation goals, measured through State Health Index (SHI) to assess performance trend and improvement opportunities. Programs recently developed include:
    - Web-based resources for managers to support employees' healthy return to work after cancer treatment.
        - *(Work Plan Transitions for People Touched by Cancer)*
    - Digital magazine featuring free resources available to all people touched by cancer.
        - *(Stronger Together)*
    - Diabetes program that promotes successful aging through lifelong learning, healthy living, and social engagement in collaboration with the National Council on Aging (NCOA), the Oasis Institute, and YMCA.
        - *(Better Choices Better Health)*
- Disease Management: The ConditionCare Program is designed to help maximize health status, improve health outcomes, and reduce health care costs of Members diagnosed with Asthma (pediatric and adult), Diabetes (Type 1 and Type 2, pediatric and adult), Coronary Artery Disease (CAD), Heart Failure (HF), and Chronic Obstructive Pulmonary Disease (COPD). These disease management programs were created and developed based on the most recent versions of nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two (2) years, and program interventions and protocols are updated accordingly.
- Health & Wellness: Programs offer a seamless integration of preventive care, wellness, case management, and care coordination to meet the needs of Members along the complete continuum

of care. Programs include: MyHealth Coach (MHC), MyHealth Advantage (MHA), Neonatal Intensive Care Program, Worksite Wellness, and Healthy Lifestyles.

Service Quality

Anthem periodically surveys Members, evaluates service performance and quality of care, and strives to provide excellent service to Members, Providers, and Facilities. Anthem analyzes trends to identify service opportunities, and recommends appropriate activities to address root causes.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to anthem.com/ca. Scroll to the bottom of the page, select the **Providers** link and **enter**. Select the **Health & Wellness** tab, then the link titled "Quality Improvement and Standards." If Members need more information or would like to contact us, they are instructed to go to anthem.com/ca, select the **Providers** link and **enter** and select **Contact Us** (on the top of the page, right side). Or they can call the Member Services number on their ID card.

Patient Safety

The strategic vision for patient safety is to establish and maintain goals in advancing patient safety. This program is structured to align with the overall mission and national patient safety strategy. Goals are to work with physicians, Hospitals, and other health care partners to reduce adverse drug events, health care associated conditions, Hospital readmission, and avoidable cost of care, as well as to develop innovative programs to accelerate improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient engagement, care management, and payment innovation. Patient safety initiatives are managed by various business units within Anthem, but tracked by a single unit. These Member- and Provider-facing initiatives/activities are designed to meet regulatory requirements, accreditation standards, and consumer needs. Whenever possible, nationally endorsed clinical metrics are used to evaluate progress.

Continuity and Coordination of Care

Anthem encourages communication between all physicians, including primary care physicians (PCPs) 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 QI program is an ongoing and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by network Providers.

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

The Quality-In-Sights: Hospital Incentive Program (Q-HIP) is the 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 improve 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)
- Centers for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (TJC)
- 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 CMS' Hospital Compare database. Q-HIP measures can be benchmarked, tracked, and compared within and among Hospitals for all patient data – regardless of the health plan carrier.

Meetings may be held annually with Q-HIP participating Hospitals. The meetings offer Hospitals an opportunity to share feedback regarding new metrics and initiatives. In addition, a National Advisory Panel (NAP) was established in 2009 to provide input during the scorecard development process. The NAP is made up of patient safety and quality leaders from health systems and academic medical centers from across the country. The NAP offers valuable advice and guidance as new measures and scoring methodologies 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 health care Provider, such as a physician, or a health care organization, such as a Hospital. Common examples of performance data would include the HEDIS quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

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

Overview of HEDIS®

HEDIS® (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used; by the nation's health plans to evaluate their performances in terms of clinical quality and customer service. HEDIS is coordinated and administered by NCQA (National Committee for Quality Assurance). Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in January, and Anthem requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted Providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs. For more information on HEDIS go to the "Providers" home page at anthem.com/ca. On the Provider home page under the Health and Wellness tab (on the blue toolbar), select the Quality and Improvement Standards link, then scroll down to "HEDIS Information."

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 health plan Members about their experiences with Anthem's health plans in the past year. This includes 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 Member dissatisfaction, and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

Health Plans report survey results to NCQA, who 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 via "Network Update" newsletters, 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).

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. We review the guidelines at least every two (2) years, 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 through the Internet. To access the guidelines, go to anthem.com/ca. On the Provider Home page, under the **Health and Wellness** tab (on the blue toolbar), select the **Practice Guidelines**, then select the link titled **Clinical Practice 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 clinical practice guidelines.

Access and Availability of Care

Anthem has a systematic approach to annually monitoring appropriate access to physician care as well as appointment wait times. Anthem monitors access through a variety of different mechanisms, including, but is not limited to:

- Compiling the rates of access and availability of care-related Member grievances and appeals at the plan level.
- Participating in an annual telephonic survey to assess physician office's compliance with appointment availability standards. The survey is sponsored by ICE (The Industry Collaborative Effort).
- Conducting an annual telephonic survey to assess physician office's compliance with the after-hours care standards. In surveying after-hours care, physician offices are called to determine whether the telephone call was answered, or not answered, by a person or a recording; had emergency instructions; had a means by which the caller could speak to a physician after hours; and an expectation as to when a return call should be expected.
- Using Member responses to the Consumer Assessment of Healthcare Provider and Systems (CAHPS® survey, a standardized Member satisfaction survey with access to relevant questions to assess compliance with routine and urgent care standards.
- Aggregate ProviderAccess® standard compliance results at the plan level and share compliance outcomes with the contracted physicians and behavioral health Providers through direct mail and Web-based *Professional Network* updates.
- Annually assessing the ratio of PCPs and high-volume specialty care physicians to Members by dividing the membership by the number of each contracted Provider type in each network.
- Assessing the ratio of physicians and high-volume specialists per California ZIP code, using software to determine compliance with the Anthem availability standards.
- Assessing the availability of physicians and high-volume specialists, using software to determine compliance with the Anthem availability standards.

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

Emergency Access Standards

California state and federal laws require health plans to follow a "prudent layperson" standard in providing directions for emergency care, and prohibits plans from denying payment for emergency services. Even if the situation was discovered not to be emergent, if any "prudent layperson" would have considered the

situation to be an emergency. A "prudent layperson" is a person who is without medical training, and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary.

Consistent with our established policy on emergency access, Anthem expects every Anthem network health care Provider to instruct their office staff and after-hours answering service staff regarding emergencies. A Member who calls their PCP's office reporting a medical emergency (whether during or after hours) are directed to dial 911 or go directly to the nearest Hospital emergency department. If emergency service is authorized by the answering service staff, this authorization is considered binding and cannot be retracted at a later date.

Facility-Financial Performance Standards

Consistent with Anthem's policy of limiting exposure to unwanted financial risks, a Facility being considered for Institutional Capitation will be subject to a pre-contractual financial review prior to entering into an Institutional Capitation contract with Anthem Blue Cross (Anthem). The potential Facility Hospital will be required to provide Anthem' representatives or employees with historical and current financial information and allow access to the Facility's books and records in order to make an examination of said records and to make copies there from. Accounting books and records will include, but are not limited to, the Facility's organizational information, general ledger, journal entries (together with appropriate back-up documentation), accounts receivable (AR), aging schedules (including details of due from accounts), risk and incentive receivables, claims inventory aging, IBNR Lag schedule, specific GL account details, trial balance, bank statements/reconciliations, certification of bank deposits, and any other data related to the financial statements that Anthem may request. The Facility contracted to provide Institutional services contemplated under this section (and paid under a Capitation agreement) shall be subject to the applicable Financial Performance Metrics as provided for under the section on PMG/Hospital Financial Review of the HMO Manual.

Upon the Facility's initial application to receive Institutional Capitation from Anthem; the following will be required:

1. Completed financial review questionnaire
2. Audited financial statements for the last three fiscal year-end periods, audited by a certified public accounting firm. The financial statements must include the balance sheet, income and cash flow statements, Auditor's Opinion, and all footnotes disclosures.
3. Business Plan/projections (monthly or quarterly) for the next three fiscal year-end periods
4. Business organization documents
5. Articles of Incorporation
6. Additional information as requested by Anthem

Any Facility that enters into an Institutional Capitation Agreement with Anthem, shall agree to provide ongoing financial information and to meet specific financial requirements as deemed necessary by Anthem as part of the plan's responsibility to evaluate and ensure the financial viability of its arrangements for the provision of health care services. The following financial information shall be required on an ongoing basis from the contracted Facility:

1. Quarterly unaudited financial statements due 45 calendar days from the end of each calendar quarter, certified by the Facility's Chief Financial Officer

2. Fiscal Year-End Audited financial statements due to Anthem 150 days after the fiscal year end
3. Other information as required by Anthem

AIM Specialty Health (AIM®)

Enhanced Patient Safety Program

AIM®, an affiliate of Anthem, has developed an enhanced Patient Safety Program including an educational website, aimspecialtyhealth.com/solutions/patient-safety/safety, and interactive Patient Safety tool, Ask AIMEE. AIM's patient safety program is targeted towards increasing awareness of radiation dose associated with advanced imaging and promoting the most effective use of these procedures.

Ask AIMEE, also located at aimspecialtyhealth.com/solutions/patient-safety/safety, allows users to select commonly ordered imaging procedures and obtain the estimated radiation dose associated with those procedures in an adult patient. The radiation dose is expressed in three different units of measurement: effective dose in millisieverts (mSv), chest X-ray radiation equivalent and natural background radiation equivalent.

Consistent with recommendations from the ACR White Paper on Radiation Dose in Medicine, AIM also informs Providers when they request an imaging procedure for a patient that has been exposed to high estimated doses of radiation from previous imaging ordered through AIM's programs. This information is provided to ordering physicians at the time an imaging request is submitted to assist them in their decision making process.

Provider Transparency and AIM's *OptiNet*®: a Cost and Quality Tool

Anthem is dedicated to helping meet the ever-changing needs of our customers and helping our Members optimize the value of their health care dollars. To better serve our Members by providing physicians with a complete quality and cost picture of *imaging and sleep* services available within our network, Anthem collects data about High-Tech Imaging and Sleep services capabilities.

Through AIM's *OptiNet* online survey tool, we are collecting data including training, imaging equipment, capacity, access and compliance with industry standards such as those established by TJC (formerly JCAHO) and the American College of Radiology (ACR). All Network Providers who perform high-tech diagnostic imaging OR sleep test/study services should complete an *OptiNet* online survey for each participating site. A site score cannot be determined until the survey is completed, and information in the surveys should be kept updated to prevent site scores from being adversely effected.

Anthem has incorporated average imaging and sleep services cost information into *OptiNet.* Cost values are determined based on the allowed amount of paid claims from up to the previous 18 months for both professional and technical component claims. Both the information collected on imaging and sleep capabilities of Anthem Providers, as well as the cost values, are made available to Anthem physicians who request preauthorization for an advanced diagnostic imaging or sleep services, via telephone or online.

When an ordering/referring physician submits a preauthorization request online, they will receive the site scores and average cost information for local imaging and sleep Providers, based on the Member's address.

CT/MRI Member Outreach Program

This Program highlights Facilities offering high-quality, affordable imaging services and now involves outreach to Anthem Members receiving services in all California counties. During this outreach, Members will have an opportunity to choose high-quality services and potentially reduce their health care expenses by selecting high-quality, lower-cost Providers. When Anthem receives preauthorization requests for certain MRI and CT services (oncology & pediatric cases excluded), Members will be called and given information so they understand the Provider choices available to them. This program is voluntary; Members are not required to choose a lower-cost option. Our goal is simply to provide Members with information to make informed choices about their health care.

Members will be contacted by an Anthem Outreach Specialist, when the Authorization granted is for a Provider with a site that meets any of the following criteria:

a) The site is without a completed *OptiNet* survey (resulting in no site score)
b) The site has a low score
c) The site has a high score, but nearby Providers with the same or better score, and have significantly lower costs, are available

Anthem Health Outreach staff will offer Members nearby sites that have good site scores and lower costs.

It is important that all Network Providers of MRI or CT services complete an *OptiNet* online survey.

If you are a servicing/imaging Provider and would like to complete a survey, or update your survey and view your site's cost information, log on to Anthem' Provider portal, ProviderAccess. Only those Providers who have completed their *OptiNet* assessment will be able to view their cost information online. Your participation in this online survey is critical to help support Anthem' quality initiative.

To login or to sign up for *ProviderAccess*, go to the *Providers* website on anthem.com/ca, and select "Medical" in the drop-down under "LOGIN." Once logged in:

1. Select the "Referral and Pre-auths" tab
2. Select the "Imaging and Specialty Drug Requests" link
3. Select "Continue>>" on the Anthem Internet Hyperlink Disclaimer page
4. Agree to the HIPAA disclaimer on the AIM ProviderPortal page
5. Select "Access your *OptiNet* Registration" to locate and select your site to be registered
6. Complete your registration

A checklist and interactive tutorial are available in the AIM portal to assist you in completing your registration. For technical assistance in completing your registration, call AIM toll-free at 1-800-252-2021. For general questions about *OptiNet*, reference the AIM FAQ's in *ProviderAccess* or contact California Network Relations by email at: CAcontractsupport@anthem.com.

! All ProviderAccess functionality is transitioning to Availity as of January 20, 2017. For more information and how to register on Availity, refer to the *Availity Web Portal (Availity)* section of this Manual

Medical Record Standards

Anthem has standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential Member care and quality review. Anthem performs medical record reviews to assess network primary care physicians (PCPs) in relation to current medical record standards. Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care and requires Providers and Facilities to comply with Anthem's standards for medical record documentation.

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

In order to pass the audits/reviews, an office must attain an overall score of 80 percent or greater on the medical record audit. If a Provider fails to meet Anthem's standard of 80 percent, a re-review is conducted within six months. Should the Provider continue to score less than 80 percent on the medical record review, the Provider would be put on corrective action that could result in termination from the network.

Medical Record Criteria

The medical record will be evaluated for the following criteria:

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

11. Age appropriate routine preventive services/risk screenings are consistently noted, i.e., childhood immunizations, adult immunizations, mammograms, pap tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

Additional Information on Anthem Quality Improvement Programs

Additional information on Anthem's Quality Improvement programs can be found on anthem.com/ca. Select the **Providers** link in left margin and select **enter** under "Welcome to Anthem" middle of page. On the Provider Home page, under the **Health & Wellness** tab (on the blue toolbar) select Quality Improvement and Standards.

Cultural Diversity and Linguistic Services

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Cultural Diversity and Linguistic Services Overview

Anthem recognizes that Providers and Facilities can encounter challenges when delivering health care services to a diverse population. Those challenges arise when Providers and Facilities need to cross a cultural divide to treat patients who may have different behaviors, attitudes, and beliefs concerning health care, or who speak a different language. Differences in patients' ability to speak or read the same language as their health care Providers may add an extra dimension of difficulty when Providers and Facilities try to encourage follow through on treatment plans.

Anthem Cultural Diversity and Linguistic Services Toolkit, called Caring for Diverse Populations, was developed to give Providers' and Facilities specific tools for breaking through cultural and language barriers in an effort to better communicate with their patients. Sometimes the solution is as simple as finding the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the door to the kind of interaction that makes treatment plans most effective: Has the individual been raised in a culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite sex? Is the individual self-conscious about his or her ability to read instructions?

This toolkit gives Providers and Facilities the information needed to answer those questions and continue building trust. It will enhance Providers' and Facilities' ability to communicate with ease, talking to a wide range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to office staff so that all aspects of an office visit can go smoothly.

We strongly encourage Providers and Facilities to access the complete toolkit:
http://bridginghealthcaregaps.com/

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base

- Encounter tips for Providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base

- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients

Resources to Communicate Across Language Barriers

- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Primer on How Cultural Background Impacts Health Care Delivery

- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services

- Identifies important legislation impacting cultural and linguistic services, including a summary of the "Culturally and Linguistically Appropriate Services" (CLAS) standards, which serve as a guide on how to meet these requirements.

Resources for Cultural and Linguistic Services

- A bibliography of print and Internet resources for conducting an assessment of the cultural and linguistic needs of a practice's patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration Effort (ICE) Cultural and Linguistics Workgroup, a volunteer, multi-disciplinary team of Providers, health plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve health care regulatory compliance through public education. More information on the ICE Workgroup may be obtained on the ICE Workgroup website: http://www.iceforhealth.org/home.asp

Cultural competency training is available on anthem.com/ca, under the Health & Wellness drop down menu select Cultural and Linguistic.

Creating an LGBT-Friendly Practice: Bridging Multicultural Health Care Gaps

What you may not know about your Lesbian, Gay, Bisexual, or Transgender (LGBT) patients may be putting their health at risk. Studies have shown that many LGBT patients fear they will be treated differently in health care settings and that this fear of discrimination prevents them from seeking primary care. Anthem joins you in striving for the best clinical outcomes for everyone, including LGBT populations. That's why Anthem has created an online experience that provides strategies, tools, and resources to Providers and Facilities interested in attracting or maintaining an LGBT patient panel. Hopefully, as a result of increasing LGBT-friendly practices, we will see an increase in primary care and prevention among LGBT patients. Like you, Anthem strives to meet the needs of our diverse membership and upholds access to consistently high-quality standards across our networks. We believe that by offering our Providers and Facilities these types of experiences, we can help keep all our Members healthy. In addition, this online experience reinforces our commitment to equality for our LGBT Member as referenced in our Provider and Facility contractual non-discrimination provisions.

Visit our *Training: Cultural and Linguistic CME Courses* Web page online for free 24/7 access to the experience – either via your computer, tablet or smartphone. You will gain an increased understanding of how to create an LGBT-Friendly Practice, which may improve the health of your patients. Approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

To view more offerings, go to anthem.com/ca > scroll to the bottom of the page and select the link, **Providers** > **Enter**. From the *Provider Home page*, under the tab *Health & Wellness*, choose the **Cultural and Linguistic** option from the drop-down menu. Once the page displays, select the link, **Training: Cultural and Linguistic CME Courses**, then the **Learn More About This Training** link.

Anthem Blue Cross Language Assistance Program

Introduction

In addition to past legislation regarding access to health care (e.g., Title VI of the 1964 U.S. Civil Rights Act; OMH 2000 CLAS Standards; California Department of Health Services Regulations), California Senate Bill 853 (Escutia (D), et. al., amended April 22, 2003) required all health care service plans to assess the needs and demographic profiles of their enrollee population and report this information to the California Department of Managed Health Care (DMHC) and California Department of Insurance (CDI) in the form of policies and procedures. These policies and procedures were designed to improve "culturally and linguistically appropriate services." The legislation also required all Plans to have a Language Assistance Program (LAP) for Members who are considered to be limited in English proficiency or "Limited English Proficient" (LEP) when a threshold number of these individuals is reached using the total membership as the population. Specifically, this threshold is defined by section 1367.04(1)(A)(i) as:

> "A health care service plan with an enrollment of 1,000,000 or more shall translate vital documents into the top two languages other than English as determined by the needs assessment as required by this subdivision and any additional languages when 0.75 percent or 15,000 of the enrollee population, whichever number is less, excluding Medicaid enrollment and treating Healthy Families Program enrollment separately indicates in the needs assessment as required by this subdivision a preference for written materials in that language."

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

Anthem provides services to hearing impaired Members. Services for hearing impaired enrollees are offered under the American Disabilities Act.

At Anthem, we believe in the strength and value of cultural diversity. We realize that communication with physicians and other health care professionals is paramount to ensuring optimum health and wellness. To facilitate communication, we offer interpretation services to eligible Members at no cost. In addition, translated documents are provided to Members in the languages required by the language assistance regulations.

I. Regulations

The threshold languages for Anthem are English, Spanish, Chinese (traditional), Korean, Tagalog, and Vietnamese. Navajo is considered a threshold language under the Patient Protection and Affordable Care Act (PPACA) when a Member resides in Arizona and seeks services in California.

DMHC Notice of LAP Availability [C] [C; HMO] [28 CCR § 1300.67.04(c)(2)(F)(v)] Non-standardized Vital Documents (e.g., denial notifications including modifications and delay letters) must include the following approved Notice of LAP Availability:

The Notice of LAP Availability must include English and the five threshold languages identified by Anthem: Spanish, Chinese (traditional), Korean, Tagalog, and Vietnamese.

Federal Notice of LEP Assistance [F] [C; PPO; ACO; BH] [29 CFR § 2590.715-2719(e)(2)(i)] Adverse Benefit Determinations (e.g., denial letters) must include the following approved Notice of LEP Assistance:

English: "If you need assistance in one of the languages listed below to understand this document you may request it for free by calling customer service at the number on your identification card or in your enrollment booklet."

- For Members with addresses in California the Notice of LEP Assistance – CA must include English and the following two threshold languages: Spanish and Chinese (traditional).
- For Members with addresses in Alaska the Notice of LEP Assistance – AK must include English and the following two threshold languages: Spanish and Tagalog.
- For Members with addresses in Arizona the Notice of LEP Assistance – AZ must include English and the following two threshold languages: Spanish and Navajo.

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

As a best practice, physicians and other health care professionals are encouraged to document the preferred spoken and written language in each patient's office chart or medical record.

LAP Services Available at no Cost to Members

The following services are offered at no cost to Members.

1. Face-to-Face Interpreters, including Sign Language. Members, physicians, and other health care professionals may call the Customer Service telephone number located on the patient's health plan identification card, or the 24/7 NurseLine after-hours, to schedule face-to-face interpretive services during business hours. Seventy-two (72) business hours are required to schedule services, and twenty-four (24) business hours are required to cancel. Interpretive services may also be scheduled by emailing **ssp.interpret@anthem.com.** Registration with the secure email is required. Members, physicians, and other health care professionals are asked to type the word "secure" in the subject line of the email.
2. TDD/TTY and Relay Services for Members with hearing or speech loss. Members may call 711, the national relay number or the relay service of their choice, and have the relay operator

contact Anthem's Member Service telephone number, which is located on the Member's identification card. Once connected, and if requested, the Anthem representative will coordinate with the appropriate area to schedule an on-site interpreter for the Member (also described above). TDD (telecommunications device for the deaf) or TTY (telephone typewriter, or teletypewriter) is an electronic device for text communication via a telephone line, used when one or more parties have hearing or speech difficulties. When communicating with the deaf by telephone, physicians and other health care professionals can contact Anthem directly to schedule interpreter services on behalf of the Member by contacting Anthem's Provider Care telephone toll-free number at 1-800-677-6669.

TDD/TTY services are also available by calling one of the following toll-free numbers. A specially trained operator will contact Anthem to help with the Member's needs: 1-800-735-2929 – English TTY or 1-800-735-2922 – English Voice.

3. Telephonic interpreter services provided at all points of contact. Professional interpreters are native or near native speakers who are proficient in health care terminology and have been evaluated on a standardized assessment tool. Professional interpreters receive training regarding the Health Insurance Portability and Accountability Act (HIPAA) and ethical standards. Points of contact include administrative, health care, and related services. Anthem's interpretation vendors are contracted to have professional interpreters available in all languages within 10 minutes of request. To assist a Member in accessing an interpreter during regular business hours, physicians and other health care professionals are instructed to have their Anthem patient call the Customer Service telephone number located on his or her health plan identification card and request the service. Alternatively, Providers may call Anthem's Provider Care Department toll-free number at 1-800-677-6669 and request to speak to an interpreter. Physicians and other health care professionals must document the use or refusal of professional interpreters by their patients.
4. Written materials are provided in six threshold languages: English, Spanish, Chinese (traditional), Vietnamese, Korean, and Tagalog. A material translated prospectively includes, but is not limited to, enrollment, eligibility and membership information, Explanation of Benefits (EOB), and notices of language assistance. Members indicate their preferred written language to receive prospectively translated materials.
5. Written materials are translated into a threshold language upon request. Materials that are Member-specific, for example denial, delay, or claims letters are sent in English with the offer of translation when requested. Translated materials are then sent to the Member no later than 21 days from the request date. To ensure the timely translation of materials, physicians and other health care professionals are instructed to encourage their patients to contact Anthem Blue Cross toll-free number 1-888-254-2721 to request translated materials. Alternately, physicians and other health care professionals can call Anthem's Provider Care Department toll-free number 1-800-677-6669 to request translation on the Member's behalf. When contacted by a contracted Provider with a Member requesting translation of documents, Anthem policy is to send the Member to their Member Services line. Member services can request a translation of documents through the Translation Correspondence Unit. Member Services telephone number is located on the back of the Member's ID card.
6. A copy of the document is required in order to complete the translation request.
7. Translators. Translators are native or near native speakers with proficiency in health care terminology. Translators have been evaluated on a standardized assessment tool and receive

training relative to HIPAA and ethical standards. Translations are written at the grade level appropriate for the audience.

8. Approved Industry Collaboration Effort Documents are available at: http://www.iceforhealth.org/library.asp?sf=&sc=APPROVED+ICE+DOCUMENTS
9. Telephone Numbers.
    - Anthem Interpreter Access: Call the Customer Service telephone number on the patient's health plan identification card or toll-free at 1-888-254-2721.
    - Anthem Translation Access (vital non-standard documents) toll-free phone number 1-888-254-2721.
    - Anthem contact for questions related to interpreter/translation toll-free number at: 1-800-677-6669.

Working Effectively With LEP Members: For successful interactions between health care professionals and LEP patients, it is important to:

- Notify the LEP Member of the services available.
- If the LEP Member does not request interpreter services, offer the service during the health care visit or contact.
- If a Member has not notified Anthem of their preferred spoken or written language, they are still entitled to language assistance services.
- If a Member brings a family member or friend to their health care visit and requests to use his or her family member or friend as an interpreter, offer the use of a professional interpreter. If the Member refuses the offer of the professional interpreter, both the offer of a professional interpreter and the Member's decision to use the family member or friend as the interpreter must be documented in the patient record. Anthem strongly discourages the use of a minor as an interpreter. However, a minor may be used in the event of an emergency if the following criteria are met: (A) The minor demonstrates the ability to interpret complex medical information in an emergency/critical situation and (B) The Member is fully informed in their primary/preferred spoken language that a qualified interpreter is available at no charge to them. If the Member refuses the offer of the qualified interpreter, both the offer of a qualified interpreter and the Member's decision to use the minor as the interpreter must be documented in the patient record.
- Speak slowly, not loudly.
- Organize information into short, simple sentences. Place important topics at the beginning and end of the conversation.
- Use open-ended questions to assess for understanding.
- If the Member initially refused interpreter services and is not demonstrating full understanding, offer interpreter services again.
- If in-person, monitor non-verbal cues, such as facial expressions, positioning and body language. These may indicate understanding or confusion.

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

- If possible, speak to the interpreter privately before the contact, providing relevant information regarding the Member and the important information to convey.

- Interpreters are not allowed to rephrase or clarify. Encourage the interpreter to request clarification or to redirect explanations as needed.
- Direct the conversation to the Member, not the interpreter.
- Use short sentences limited to a single concept if possible.
- Allow adequate time for the interpreter to convey the information in the Member's language.
- Avoid medical jargon or technical explanations unless they are requested by the Member.
- Avoid interrupting the interpreter.
- If the Member's non-verbal cues indicate confusion, ask him or her to summarize or restate what has been communicated.

Additional Resources

- Information Available on Department of Managed Health Care (DMHC) Website: Informational notices explaining how Members may contact their health services plan, file a complaint with their health services plan, obtain assistance from the DMHC, and seek an independent medical review are available in specific non-English languages through the DMHC's website. Representatives from the DMHC may be reached by using the toll-free phone number 1-888-466-2219 or FAX number 1-916-255-5241. Alternatively, the notices and translations can be obtained online at http://www.hmohelp.ca.gov/ for downloading and printing. In addition, hard copies may be requested by submitting a written request to:

  California Department of Managed Health Care
  980 9th Street, Suite 500
  Sacramento, CA 95814

- Information Available on California Department of Insurance (CDI) Website: Information explaining how Members may file a complaint or request assistance from the CDI may call the Consumer Hotline toll-free numbers at 1-800-927-HELP (4357) or 1-800-482-4833 TDD. The CDI may also be contacted through their Website at: http://www.insurance.ca.gov/
- California Office of the Patient Advocate: http://www.opa.ca.gov, or toll-free phone numbers 1-866-466-8900,or 1-866-499-0858 TTY.

We sincerely hope that this information is useful in your everyday encounters with LEP Members. Contact Anthem Provider Services toll-free phone number at 1-800-677-6669 if you have any questions or require assistance with the LAP.

Health and Wellness

Member Health & Wellness Programs 2

Member Health & Wellness Programs

Anthem seeks to improve the lives of the Members we serve. Anthem provides a unique blend of health and wellness programs to help Members reach their total well-being goals. A quick overview of the programs and services Anthem offers is available by going to the anthem.com/ca and selecting **Health & Wellness tab** (on the blue toolbar), or select this *Health & Wellness* link.

Centers of Medical Excellence

Anthem Centers of Medical Excellence Transplant Network 2
Centers of Medical Excellence 2

Anthem Centers of Medical Excellence Transplant Network

The Anthem Centers of Medical Excellence (CME) for transplant consists of a network of approved providers and facilities (the "Network") for the following transplant procedures: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, liver/kidney, simultaneous kidney/pancreas and pancreas. Individual transplant procedures (e.g., heart, lung or combination heart/lung) are referred to in the Anthem Centers of Medical Excellence Transplant Manual as a "Program." For additional information refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* found in the *Exhibits* section.

For information on which Anthem products will have access to the transplant network, refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual*,

All Anthem Blue Cross (Anthem) Members, including local, national and affiliates, have Network access under the terms of the *Stand Alone Transplant Agreement* or Transplant Attachment to the *Hospital Agreement* between you and Anthem. Refer to your *Hospital Agreement* or *Stand Alone Transplant Agreement*.

The Anthem Centers of Medical Excellence transplant certification procedures are designed to ensure Members that all Network transplant centers meet health plan established clinical criteria and levels of service. Participating transplant centers are selected based on their ability to meet defined clinical criteria that are unique for each transplant type.

Refer to the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* in the *Exhibits* section of this Manual.

Centers of Medical Excellence

Anthem currently offers access to Centers of Medical Excellence (CME) programs in solid organ and blood/marrow transplants, bariatric surgery, cardiac care, complex and rare cancer, spine surgery, and knee and hip replacement surgery. As much of the demand for CME programs has come from National Accounts, most of our 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 Hospitals as Blue Distinction Centers for Specialty Care™ (BDC). Using objective information and input from the medical community, the BCBSA has designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+, efficiency.

Anthem Members have access through this program to Centers of Medical Excellence, including Blue Distinction Centers for Specialty Care for transplant, bariatric surgery, cardiac care, complex and rare cancer, spine surgery, and knee/hip replacements.

For transplants, Members also have access to the Centers of Medical Excellence Transplant Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ or marrow transplantation representing transplant 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 designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and 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 our programs can be accessed online on our website anthem.com/ca under the "Health & Wellness" tab, choose Centers of Medical Excellence from the drop-down menu.

Transplant

- Blue Distinction Centers for Transplant (BDCT) launched in 2006. More than 122,276 people in the United States were registered for organ donations from one of the nation's more than 800 transplant programs in 2015.
- 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 Centers of Medical Excellence (CME) Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, our Members have access to 300 transplant specific programs for heart, lung, combined heart/lung, liver, pancreas, combined kidney/pancreas and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, approximately 610,000 people die of heart disease in the United States every year – that's one in every four deaths.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008.
- Morbid obesity is widely recognized as a contributor to serious health risks. According to the Centers for Disease Control and Prevention, approximately 72 million Americans are obese. The American Society for Metabolic and Bariatric Surgery estimates that approximately 179,000 bariatric surgeries were performed in 2013. Blue Distinction provides objective information to help patients make informed decisions when choosing a provider for bariatric surgery.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS), and is subject to periodic re-evaluation as criteria continue to evolve.
- The Blue Distinction Centers for Bariatric Surgery program is available to comprehensive centers with inpatient capability or freestanding ambulatory surgical centers (ASCs). The Blue Distinction Centers for Bariatric Surgery program designation includes two types:
    - Gastric Stapling
    - Gastric Banding

Complex and Rare Cancers

- Blue Distinction Centers for Complex and Rare Cancers® launched in 2008.
- Blue Distinction Centers for Complex and Rare Cancers program offers access to designated facilities for the treatment of 13 complex and rare cancers including esophageal cancer, pancreatic cancer, liver cancer, rectal cancer, gastric cancer, bone tumors, soft tissue sarcomas, brain tumors – primary, non-metastatic malignancies, bladder cancer, thyroid cancer – medullary or anaplastic, ocular melanoma, and head and neck cancers.
- Complex and Rare Cancers comprise approximately 15 percent of new cancer cases each year. The Blue Distinction Centers for Complex and Rare Cancers program evaluates facilities on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for complex and rare cancers. The Blue Cross and Blue Shield Association recognizes that the majority of patients' multidisciplinary treatment may be best accomplished by integrating the expertise available in a Blue Distinction Center with locally available treatment resources, especially for outpatient chemotherapy and radiotherapy, based on individual circumstances and patient preference. Optimal support of a patient's comprehensive cancer care needs may be achieved by coordination of care between the patient and their family, local physicians, the Blue Distinction Center and their local Blue Cross and Blue Shield Plan.
- The Blue Distinction Centers for Complex and Rare Cancers program was developed in collaboration with the National Comprehensive Cancer Network (NCCN), with input from a panel of nationally recognized clinical experts and utilizing published evidence, where available.

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, and your doctor can guide you toward the most appropriate recommendation for your 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.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, we have 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.
- 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 surgeries.

Maternity Care

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care (coming in 2016) will include health care facilities with demonstrated expertise and a commitment to quality care during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data, which includes the Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS).

More information on our programs can be accessed online on our website anthem.com/ca under the "Health & Wellness" tab, choose Centers of Medical Excellence from the drop-down menu.

Disclaimer: For further information on services covered under a Member explanation of coverage, contact your local Blue Plan.

Member Grievance and Appeal Process

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Introduction

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

The Anthem Grievances and Appeals Department (G&A) administers the formal grievance and appeal process. G&A is responsible for documenting, investigating, resolving, and responding to Members' issues in a timely and accurate manner.

The Anthem Behavioral Health (BH) G&A Department is responsible for addressing Member grievances and appeals related to behavioral health care services and treatment. The term "G&A" used throughout this section refers to both medical G&A and BH G&A, unless otherwise specified.

Members have up to 180 calendar days from the date of an incident, or from the date of receipt of an adverse determination (denial), to submit a grievance/appeal to Anthem Blue Cross, unless otherwise specified in their Evidence of Coverage (EOC). If a party shows good cause, Anthem may extend the timeframe.

Member Representation

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

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

For the purposes of this section, the term "Member" will refer to the Member, designated representative or health care Provider/Facility acting on behalf of the Member.

G&A follows HIPAA privacy standards to ensure Member, medical record and data confidentiality.

Right to Submit Additional Information During Appeal Process

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

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

Grievance and Appeal Resolution Timeframes

- G&A must resolve standard (non-urgent) Member grievances and appeals within 30 calendar days from the Anthem receipt date. G&A will consider the Member's medical condition in determining whether a sooner response time is indicated.
- G&A must resolve expedited (urgent) grievances and appeals within 72 hours from the Anthem receipt date.

Custodial Parent Rights

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

Members with Linguistic and Cultural Needs, Limited English Proficiency, and Other Communicative Impairments or Disabilities

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

Refer to the *Cultural Diversity and Linguistic Services* section of this Manual for additional information on Cultural Diversity and Linguistic Services.

Background Information

The California Department of Managed Health Care (DMHC) regulates managed health care HMO/POS/PPO plans and Medicare Supplement business in California. The California Department of Insurance (CDI) regulates Anthem Blue Cross Life and Health Insurance Company plans and Medicare Supplement business. Centers for Medicare & Medicaid Services (CMS) regulates Medicare Supplement business in California. Under applicable law and regulations, the DMHC requires that every managed care health plan establish and maintain a grievance system through which Members may submit grievances to the plan.

Definitions

Grievance is a written or oral expression of dissatisfaction regarding the Plan and/or Provider, including quality-of-care concerns, and shall include a complaint, dispute, request for reconsideration or appeal made by a Member. When the plan is unable to distinguish between a grievance and an inquiry, it shall be considered a grievance.

Appeal is a formal request for reconsideration or reversal of an adverse determination (denial) made by Anthem.

Benefit Appeal pertains to the denial of a health care service substantially based on a finding that the particular service is excluded as a benefit under the terms and conditions of the Member's benefit plan.

Clinical Appeal is a review of a prospective, concurrent or retrospective adverse determination where a plan, a contracted physician reviewer or organization, or an independent medical review (IMR) organization's clinical interpretation is required to make the appeal determination.

Prudent Layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment.

Same Specialist refers to a practitioner with similar credentials and licensure as those who typically treat the condition or health problem in question in the appeal.

Similar Specialist refers to a practitioner who has experience treating the same problems as those in question in the appeal, in addition to experience treating similar complications of those problems.

Multiple Issues (Member Submits a Grievance and Appeal) It is possible to have an appeal in which the Member also expresses a quality-of-care or service concern (grievance). The appeal and grievance are reviewed simultaneously through the appropriate processes. For example, a quality-of-care or service concern (grievance) that also involves a denial of health care services (appeal) are processed through the Member grievance process and Member appeal process, respectively.

Peer Review Quality-of-care issues involving Anthem participating Providers and Facilities are evaluated through the Anthem quality assurance/peer-review processes. The details and any actions taken as a result of peer review are privileged information and protected by Health and Safety Code Peer Review Statutes. As such, Anthem will not disclose any information to the Member regarding a peer-review case.

G&A Staff and Scope of Responsibility G&A is comprised of a team of board-certified physicians (medical directors), nurses, behavioral health clinicians, and G&A analysts and BH coordinators trained in the G&A process. The G&A team is charged with resolving Member grievances and appeals through an equitable, timely and consistent process, and communicating resolutions in a clear, concise manner.

The Anthem Blue Cross Grievance/Appeal Officer has primary responsibility for the Anthem grievance and appeal process and monitors the operation of the system on a continuous basis to identify any emergent patterns of grievances/appeals. This individual is also responsible for ensuring compliance with reporting requirements.

The G&A Medical Directors are board-certified physicians in a variety of specialties, with current and active, unrestricted medical licenses. The medical directors are responsible for clinical review, oversight and final decision-making on quality-of-care grievances, medical necessity and investigational appeals. Appeals involving medical necessity and investigational treatment are also reviewed by a peer clinical reviewer (PCR) in the same or similar specialty as the area of care under review, as appropriate.

Peer Clinical Reviewers (PCRs) are health care professionals with current and active unrestricted licenses to practice medicine and are board certified by a specialty board approved by the American Board of Medical Specialists (doctors of medicine) or the Advisory Board of Osteopathic Specialists (doctor of osteopathic medicine). PCRs who participate in the review of clinical appeals must be in the same or similar specialty that typically manages the medical condition, procedure or treatment under review. They render expert opinions and recommendations on clinical issues.

G&A Clinical Staff includes licensed nurses and licensed behavioral health clinicians, who coordinate the review and investigation of clinical grievances until resolution.

G&A Analysts are non-clinical staff responsible for the review and resolution of administrative aspects of grievances and appeals.

G&A Clinical Associates, G&A Risk Team, G&A Training Staff, Behavioral Health Clinicians and an Audit Team handle special projects and tasks including, but not limited to, the following:

- Investigating and responding to Member regulatory complaints, and regulators' request for information/records to facilitate the independent medical review (IMR) process
- Training and mentoring G&A associates on all aspects of the grievance and appeal process, including changes in regulatory and accreditation standards as applicable, and correct usage of the G&A database documentation system
- Ensuring that G&A policies and procedures are compliant with regulatory and accreditation standards, and educating staff of any policy changes that affect the processing of grievances/appeals
- Internal audits of G&A cases to ensure compliance
- Coordination of review of cases referred to the Anthem Blue Cross Peer Review Subcommittee and the BH Peer Review Subcommittee and recording minutes of the meeting
- Trend analysis of grievances and reporting results to the designated medical director for further action, as appropriate.

Initial Determination Process and Denial Notification Procedures

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

Process for Submitting Member Grievances and Appeals to Anthem

Members may request a grievance or appeal regarding any denial of authorization resulting from a request for a prospective, concurrent or retrospective review of health care services. Member grievances and appeals may be submitted in writing, verbally, by FAX or online via the Internet at anthem.com/ca. Grievance forms are posted in both Spanish and English on the website. The completed grievance form is then routed to the Customer Service Inquiry Tracking System for distribution to the appropriate G&A area. The Member may also print the form, complete it, and mail it to Anthem Blue Cross at the address below.

The Member should document the circumstances surrounding the grievance/appeal and submit this information along with any available medical documents, including medical records or claims to Anthem. Members may refer to their EOC or contact Anthem Blue Cross Customer Service for further information on the G&A process. Members may submit a grievance and/or appeal in writing to G&A at the following address:

Anthem Blue Cross
P.O. Box 4310
Woodland Hills, CA 91365-4310
FAX: 1-818-234-1089

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

Blue Shield of California
P.O. Box 272510
Chico, CA 95927
Phone: 1-800-824-8839 (toll free)

Behavioral Health Grievances & Appeals (BH G&A)

The Anthem Behavioral Health Utilization Management (BH UM) Department reviews authorization requests for certain types of health care services. When BH UM denies a request for health care services, benefits or payment of a claim, a letter is issued to the Member explaining the rationale for the denial and how to file an appeal. Appeals for Behavioral Health issues are processed by the BH G&A department. BH G&A is responsible for the investigation and resolution of complaints related to Behavioral Health care and works directly with Anthem Providers and Facilities to obtain information necessary for the review of medical necessity appeals and quality of care/service cases. Member grievances and appeals may be submitted verbally, in writing, or electronically (i.e., by mail, telephone, FAX, or online). The BH G&A department toll-free FAX number is 1-877-487-7394. Members and their representatives also have the option of submitting grievances/appeals online to Anthem via the Internet. The grievance website is accessed at anthem.com/ca.

Members may mail a written grievance/appeal to BH G&A at the following address:

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

Acknowledgement and Investigation of Appeals

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

a. The date the grievance was received by the health plan
b. A general explanation of the grievance process and timeframe
c. The name, address and phone number of the health plan representative who may be contacted about the grievance
d. A statement that the Member may submit additional written comments, documents or other information in support of the grievance
e. Plans regulated by the California DMHC must include the DMHC's toll-free telephone number, California Relay Services' telephone number, and the DMHC's Internet address in 12-point boldface font

Anthem will obtain the necessary medical information used in the initial denial, as well as additional medical information from the Provider/Facility, as appropriate. When a request for information is sent, the Provider/Facility is required to respond within seven to 10 calendar days of the request, or sooner depending on the clinical urgency of the case.

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

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

After Anthem has completed its review, a written statement of its resolution is sent to the Member and Provider within 30 calendar days of receiving the grievance/appeal. Appeal denial letters provide the rationale and criteria used in the decision and additional dispute resolution rights as stated in the Member's EOC, including the right to request an independent medical review (IMR), as applicable. Members have a right to request a copy of the criteria used in the decision, as well as copies of relevant documents and records relied on in the appeal review. There is no charge to the Member for this information. Members may request this information by calling G&A toll-free phone number 1-800-365-0609, or the TDD line toll-free number at 1-866-333-4823 for the speech and hearing-impaired.

A written request for information should be mailed to:

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

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

Blue Shield of California
P.O. Box 272510
Chico, CA 95927
Phone: 1-800-824-8839 (toll free)

Expedited Appeals

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

When a grievance or appeal meets expedited criteria, Anthem must immediately notify the Member of the right to request assistance from the DMHC or CDI, as applicable to the Member's plan, and provide the Member with the DMHC or CDI's toll-free number and TDD line. Members are not required to participate in Anthem's' expedited grievance or appeal process, prior to contacting the DMHC/CDI for assistance.

When an appeal is expedited, all necessary medical information is gathered to make a determination. As needed, the Provider/Facility will be asked to submit medical records to Anthem within 24 hours of the request. Expedited appeals must be resolved within 72 hours of the Anthem receipt date. The Member and the Provider/Facility are notified verbally of the decision within 72 hours of the plan receipt date. Verbal notification is followed by written notification within three calendar days of receipt. The written notice will include the decision, rationale, applicable review criteria used in the decision and, if denied, a description of further dispute resolution options, which may include the right to request an IMR.

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

Access to the Behavioral Health Medical Director
If you wish to speak with the Behavioral Health Medical Director, you may call the toll-free phone number 1-800-728-9498 and ask the operator to connect you with the Medical Director.

Emergency Care and Services

Emergency care is covered, in accordance with the terms and benefits of the Member's EOC, and the requirements set forth by the Health and Safety Code related to emergency services. The timeframe for resolution of appeals involving post-service emergency services is 30 calendar days from receipt of the appeal by Anthem.

In accordance with *Health and Safety Code, Section 1368.02(b)*, a Member's grievance rights in California include the right to request an IMR for payment disputes regarding the denial of emergency or urgently needed care.

Background and Scope

Section 1371.4 of the Health and Safety Code requires the health plan (plan) to pay benefits for emergency services, even when the care is not authorized. The plan must pay health care Providers for emergency services, until the care results in stabilization of the Member, unless:

1. The plan reasonably determines that emergency services were not rendered, or
2. The Member did not require emergency services, and the Member should reasonably have known that an emergency did not exist (prudent lay person standard).

The plan, or its contracting health care Providers, must provide 24-hour access for Members and health care Providers/Facilities to obtain timely authorization for Medically Necessary care. This includes follow-up care after a Member's emergency condition has been stabilized, but the treating physician believes the Member may not be safely transferred or discharged. A physician and surgeon will be available for consultation and for resolving disputed requests for authorization.

If there is disagreement between the plan or its contracting health care Provider and the treating physician regarding the need for further care, the plan or its contracting health care Provider may assume responsibility for the care of the patient as follows:

- Medical personnel contracting with the plan personally take over the care of the patient, within a reasonable amount of time after the disagreement, or
- A general acute care Hospital having a contract with the plan agrees to accept transfer of the Member.

Note: If the plan fails to satisfy the above requirements, further necessary care is deemed as authorized by the plan. Payment for this care may not be denied.

The plan may delegate the various responsibilities specified above to contracting medical professionals.

Section 1317.1 of the Health and Safety Code requires that the plan ensure coverage for emergency mental health services. The plan must also ensure coverage for an additional screening, examination and evaluation by a physician or other appropriate personnel, to determine if a psychiatric emergency exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition.

Out-of-area Emergency and Urgently Needed Care

The health plan is required to pay benefits for both emergency services and urgently needed services obtained outside the plan service area ("out-of-area"). Members who seek care out-of-area must submit their bills directly to Anthem for processing.

For FEP PPO: Professional claims are processed by the Blue Cross and Blue Shield Plan in the state where the services were rendered.

Definitions

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain), such that the absence of immediate medical attention could reasonably be expected to result in any one of the following:

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions
3. Serious dysfunction of any bodily organ or part
4. Active labor, which means labor at a time during which either of the following would occur:
   a. There is inadequate time to arrange a safe transfer to another Hospital prior to delivery
   b. A transfer may pose a threat to the health and safety of the patient or unborn child
5. The specific situation is also defined as an emergency if the Member ("prudent layperson" rule) perceives that the situation could permanently endanger their health if medical treatment is not received immediately

Urgently needed services are those services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury or complication of an existing condition for which treatment cannot be delayed until the Member returns to the plan's service area.

Urgently needed services also include maternity services necessary to prevent serious deterioration of the health of the Member or the Member's fetus, based on the Member's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until return to the plan's service area.

Emergency services and care means medical screening, examination and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician, to determine if an emergency medical condition or active labor exists and, if it does, the care, treatment and surgery by a physician necessary to relieve or eliminate the emergency medical condition within the capability of the Facility.

Emergency services and care also means an additional screening, examination and evaluation by a physician or other personnel to the extent permitted by applicable law and within the scope of their licensure and clinical privileges, to determine if a psychiatric emergency medical condition exists, and the care and treatment necessary to relieve or eliminate the psychiatric emergency medical condition, within the capability of the Facility.

Patient stabilization occurs when, in the opinion of the treating Provider, the patient's medical condition is such that, within reasonable medical probability, no material deterioration of the patient's condition is likely to result from, or occur during, a transfer of the patient.

Prudent layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary. A medical emergency exists when a reasonable and prudent layperson could expect that the absence of medical attention would result in serious:

- Jeopardy to the health of the patient;
- Impairment of bodily functions; or
- Dysfunction of any bodily organ or part.

Requests for Investigational Treatment, Including Clinical Trials (AB 55 Health and Safety Code, Section 1370.4)

If a request for investigational treatment is denied, Anthem UM will notify the Member and the Member's practitioner in writing of the basis for the denial and will provide the applicable criteria used to make the decision. In addition, the Member is informed of further dispute resolution mechanisms, including the right to IMR, as applicable to the Member's plan.

Additional Dispute Resolution Mechanisms Available to Members

If the Member continues to be dissatisfied with the resolution of his/her appeal, or if the appeal has not been resolved by Anthem after at least 30 days, the Member may submit the appeal to the appropriate regulator (e.g., DMHC,CDI or OPM), as applicable. If the Member's case involves an imminent threat to his/her health, as described above, the Member is not required to complete the Anthem Blue Cross grievance/appeal process or wait at least 30 days, but may immediately submit their appeal to the DMHC/CDI/OPM, as applicable.

Note: Not all PPO plans are under the jurisdiction of the DMHC, CDI, or the OPM. A Member may be an employee of a state, federal or administrative services only (ASO) group. If this is the case, Anthem will advise the Member to refer to his or her EOC for information regarding further dispute resolution options.

Independent Medical Review (IMR)

Under *California Health and Safety Code Sections 1370.4* and *1374.30*, and *California Insurance Codes Sections 10169* through *10169.5*, a Member may request an IMR through the DMHC, CDI, or OPM (as applicable) for Anthem denials regarding:

1. Services that are denied, delayed or modified by Anthem based on a finding that the services are not Medically Necessary;
2. Investigational services denied by Anthem Blue Cross when the patient is diagnosed with a life-threatening or seriously debilitating condition; or
3. Denied claims for emergency services or out-of-area urgently needed care.

A Member usually must participate and complete the Anthem 30-day grievance/appeal process before applying for an IMR, except in those cases where the DMHC determines the case should be expedited. Members may also apply for an IMR after the initial denial of a request for investigational treatment. The formal IMR application and instructions are enclosed with the Anthem denial letter. The Member may apply for an IMR within six months of the denial. The Member will pay no application or processing fee of any kind.

The application for IMR will be received and processed directly by the DMHC/CDI/OPM. The DMHC/CDI/OPM is the final arbiter on whether a case qualifies for IMR. If the case qualifies for IMR, the independent medical review organization (IMRO) designated by the DMHC/CDI/OPM must render a determination within 30 days for non-expedited cases and within three days for expedited cases.

IMRs are performed through an accredited professional review organization with panels of credentialed and pre-screened medical specialists available to provide the analysis and determination necessary. The medical specialists are selected to perform reviews in a particular case based on their professional and clinical expertise, after ensuring they are free from any conflicts of interest in the particular case. The decision of the IMRO is binding on Anthem.

At the conclusion of the Member's appeal review by the DMHC/CDI/OPM, or prior to and instead of review of the Member's case by the DMHC/CDI/OPM, the Member has the right to seek legal redress through binding arbitration, if contractually applicable.

Releasing Information to Members

Anthem is committed to maintaining the highest level of confidentiality for its Members' medical records.

As part of the grievance/appeal process, Members have a right to request a statement of the clinical rationale, criteria and copies of relevant documents used in the Member's appeal decision by G&A. To obtain such information, Members may call G&A directly using the toll-free number at 1-800-365-0609 or the TDD line toll-free number at 1-866-333-4823, or send a written request to the following address:

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

FAX: 1-818-234-1089

Confidentiality of Medical Information

As a participating Provider, confidentiality is critical to both Members and families undergoing assessment and treatment for behavioral health conditions. Anthem supports this need for confidentiality and agrees to take all reasonable precautions to prevent the unauthorized disclosure of any and all records related to Anthem Providers. Anthem requires that participating Providers adhere to these same standards.

Records maintained as part of the Member grievance and appeal resolution process are considered confidential and are maintained in compliance with legal requirements. These documents include Member grievances and appeals, practitioner and Provider responses, medical records, committee review documents, consultant reviews, and committee minutes.

To make a determination regarding a Member grievance and/or appeal, it may be necessary to request copies of medical records and any supporting documentation that will assist with the review. For outpatient records, state law prohibits Providers and health care service plans from releasing specified medical information regarding an individual, unless the Member is notified. Thus, as required by law, Anthem Blue Cross will notify the Member within 30 calendar days of receipt of the grievance or appeal that the information listed as follows has been requested of their practitioner:

Medical Records and Supporting Documentation

1. Diagnosis and clinical risk assessment
2. Summary of:
    a. Current complaints and symptoms
    b. Psychosocial situation
    c. Psychiatric and medical history
    d. Substance use

e. Treatment plan and goals
f. Releasing information to Members

Anthem Blue Cross HMO/POS/PPO Grievance Process

Review of Quality-of-care and Service Issues

The Quality Management 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. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Member grievance, the Member is sent a resolution letter within thirty (30) calendar days of Anthem's receipt of the grievance. The Member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

Significant quality of care issues may be elevated to the regional Peer Review Committee for Second Level Peer Review. This may result in a subsequent referral to the appropriate Credentials Committee.

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective action planning.

Corrective Action Plans (CAP)

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions, which can include one or more of the following: a CAP from the Provider and/or Facility, CME, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee.

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.

Severity Levels for Quality Assurance

Quality of Care		
Level	Points Assigned	Description
C-0	0	No quality of care issue found to exist.
C-1	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/Provider to respond to a Member grievance regarding a clinical issue despite two requests per internal guidelines.
C-4	10	Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.
C-5	15	Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.
C-6	25	Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.

Quality of Service		
Level	Points Assigned	Description
S-0	0	No quality of service or administrative issue found to exist.
S-1	0	Member grievances regarding practitioner's office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.
S-2	5	Communication, administrative, or documentation issue with no adverse medical effect on Member.
S-3	5	Failure of a practitioner/Provider to respond to a Member grievance despite two requests per internal guidelines.
S-4	5	Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.

Trend Threshold for Analysis

Quality of Care and Service Trend Parameters

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1

- 4 cases with a leveling of C-2 and S-2
- 4 cases with a leveling of C-3 and S-3
- 4 cases with a leveling of C-4
- 2 cases with a leveling of C-5
- 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
- 3 cases with a leveling of S-1 (for a specific office location in a 6 month period); refer for site visit
- 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitutes a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a Provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for Provider quality of service QOS issues are reviewed by a Medical Director and may be forwarded to the applicable Provider Review Committee if indicated by the Medical Director.

Corrective action plans received for QOC issues are reviewed by the Medical Director and may be forwarded to the applicable local Peer Review Committee for further review and follow up, as appropriate.

A Provider who does not submit the corrective action plan by the deadline (unless an extension is approved by G&A) or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.

Description of Members' Right to IMR for Investigational Treatment Denials

In accordance with *Health and Safety Code, Section 1374.30*, a Member may apply for an IMR after the plan has denied a request for investigational therapy for a life-threatening or seriously debilitating disease. Members must be notified of their right to IMR within five business days of the **initial** decision to deny coverage. Requests for IMR will be received and processed by the DMHC or the CDI, as applicable to the Member's plan.

The IMR process outlined as follows examines the health plan's decisions regarding investigational therapies for Members meeting all of the following criteria:

1. The Member has a **life-threatening** or **seriously debilitating** medical condition or chronic condition.
   - **Life-threatening** means either or both of the following:
     - Diseases or conditions where the likelihood of death is high, unless the course of the disease is interrupted
     - Diseases or conditions with potentially fatal outcomes, where the end-point of clinical intervention is survival
   - **Seriously debilitating** means diseases or conditions that cause major irreversible morbidity

2. The Member's physician certifies that the Member has a life-threatening or seriously debilitating condition, as defined above; for which standard therapies have not been effective in improving the

Member's condition; for which standard therapies would not be medically appropriate for the Member; or for which there is no more beneficial standard therapy covered by the plan than the therapy proposed.

3. Either (a) the Member's physician, who is under contract with, or employed by, the plan or PMG/IPA, has recommended a drug, device, procedure or other therapy that the physician certifies, in writing, is likely to be more beneficial to the Member than any available standard therapies; or (b) the Member, or the Member's non-contracted physician, who is a licensed, board-certified or board-eligible physician qualified to practice in the area of specialty appropriate to treat the Member's condition, has requested a therapy, based on two peer-reviewed scientific studies published by medical journals that meet nationally recognized requirements for scientific manuscripts; and the therapy is likely to be more beneficial for the Member than any available standard therapy; and the Member has been denied coverage by the plan for a drug, device, procedure or other therapy recommended by the Member's physician.
4. The specific drug, device, procedure or other recommended therapy would be a Covered Service, except for the plan's determination that the service is investigational.

Reference to "medical and scientific evidence" means:

1. Peer-reviewed scientific studies published in, or accepted for publication by, medical journals that meet nationally recognized requirements for scientific manuscripts and submit most of their published articles for review by experts who are not part of the editorial staff.
2. Peer-reviewed literature, biomedical compendia and other medical literature that meets the criteria of the National Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medicus (EMBASE), Medline and MEDLARS database Health Services Technology Assessment Research (HSTAR).
3. Medical journals recognized by the Secretary of Health and Human Services, under *Section 186(t)(2)* of the Social Security Act.
4. The following standard reference compendia: The American Hospital Formulary, Service-Drug Information, American Medical Association Drug Evaluation, American Dental Association Accepted Dental Therapeutics and United States Pharmacopoeia-Drug Information.
5. Findings, studies, or research conducted by, or under the auspices of, federal government agencies and nationally recognized federal research institutes, including the Federal Agency for Health Care Policy and Research, National Institutes of Health, National Cancer Institute, National Academy of Sciences, CMS, Congressional Office of Technology Assessment, and any national board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services.
6. Peer-reviewed abstracts accepted for presentation at major medical association meetings.

If a Member wishes to proceed with an IMR, he or she should complete and sign the following forms from the applicable agency (Anthem includes the IMR application/instructions and pre-addressed envelope to the DMHC or CDI in denial letters to Members):

Department of Managed Health Care (DMHC)*

- *IMR Application/Complaint Form*
- *IMR Application/Complaint Form Instruction Sheet*
- *Physician Certification Form*
- *Authorized Assistant Form*

- *Pre-addressed Envelope to the DMHC*

California Department of Insurance (CDI)*

- *IMR Application*
- *IMR Application Instructions*
- *Physician Certification Form*
- *Authorization for Release of Medical Records and Designation of IMR Agent*
- *Pre-addressed Envelope to the CDI*

*Note: To obtain the most up-to-date forms, Members may contact Anthem Customer Service at the telephone number on the back of their health care identification (HCID) card.

The IMR application form should then be forwarded by the Member to the DMHC or the CDI. The Member's physician should complete the Physician Certification form for an experimental/investigational denial. The Member or the physician may, but need not, supply additional medical records, or any further information, unless otherwise instructed by the DMHC or CDI.

The clinical experts with the IMR organization selected by the DMHC or CDI will render their analyses and recommendations within 30 days (three days if expedited) of receiving the request. The review will be expedited, if the Member's physician determines that the proposed therapy would be substantially less effective if not promptly started. The reviewers may ask for up to three more days if there was any delay in providing them with complete medical records and any additional information.

Terminal Conditions

If the Member's illness is considered terminal, the Member has the right to request a conference with Anthem to discuss this denial.

For purposes of this section, a terminal illness is an incurable or irreversible condition that has a high probability of causing death within one year or less.

Request for Conference

A request for a conference with a health plan representative can be obtained by either calling Anthem Blue Cross G&A Department toll-free phone number 1-800-365-0609, or the TDD Line toll-free number at 1-866-333-4823 or by sending a written request to the following address:

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

The Member may request a conference by completing the Member grievance form. Upon receiving the request, Anthem will provide the Member, within 30 calendar days, with an opportunity to attend a conference and to review the information contained in the denial. The conference will be conducted by an Anthem medical director or his/her designee who has authority to determine the disposition of the complaint.

Aside from the Member's attendance, the Member may designate a representative to attend with the Member or in his or her place. If the patient is a minor or incompetent, the parent, guardian or conservator of the Member, as appropriate, may attend.

However, the conference will be held within five business days if the treating participating physician determines, after consultation with the health plan medical director or his or her designee, based on standard medical practice, that the effectiveness of either the proposed treatment, services, supplies, or any alternative treatment, services or supplies covered by the plan would be materially reduced if not provided at the earliest possible date.

If the Member or the Member's physician needs additional information, they should call Anthem Blue Cross G&A Department toll-free number 1-800-365-0609 and ask to speak to a department manager.

California Department of Insurance

Members can contact CDI toll-free telephone number 1-800-927-HELP (4357) or by FAX at 1-213-897-5891.

Department of Managed Health Care (DMHC) Required Notification to Members Regarding Grievance and Appeals Management Process

Note: The following information is provided to help you assist Members in understanding the G&A process, and can be found in their EOC. Following is the notification given to Members regarding the G&A review process:

If you have a question or concern, call the toll-free Customer Service number on your HCID card, or write to Anthem.

If you are not satisfied with the first option and wish to file a grievance or appeal, call again and ask for a *Grievance* form, or ask the Customer Service representative to complete the form over the telephone. Or, you may file a grievance on the Internet at anthem.com/ca.

Anthem will review your grievance and respond in writing within 30 calendar days. If the nature of your concern involves an imminent threat to your health, the review will be expedited and must be resolved within 72 hours.

If the nature of your concern involves an imminent threat to your health, or if Anthem does not respond within 30 days, you may submit your concerns to the California DMHC or CDI.

The following procedure applies only to fully-insured plans regulated by the DMHC:

California Department of Managed Health Care (DMHC)

The California DMHC is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll-free at 1-800-365-0609 or at our TDD line toll-free number 1-866-333-4823 for the speech and hearing impaired and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an IMR. If you are eligible for an IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are investigational in nature, and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number 1-888-HMO-2219 or a toll-free TDD line number at 1-877-688-9891 for the hearing and speech impaired. The department's website hmohelp.ca.gov/ has complaint forms, IMR applications forms and instructions online.

The plan's grievance process and the DMHC's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your choice not to use these processes does not preclude your use of any other remedy provided by law.

ERISA

If the Member's plan is governed by Employee Retirement Income Security Act, 29 U.S.C. 1001, et. seq. (ERISA) *Section 502 (a)(I)(B)*, the Member may have the right to bring a civil action against the plan. This right can be exercised when all required reviews of the claims, including the appeal process, have been completed and the claim was not approved, in whole or in part, and the Member disagrees with the resolution.

The following procedure applies only to those contracts that are governed by ERISA:

- If your claim has been denied, in whole or in part, and your group health plan is subject to ERISA, you may be entitled to additional rights. Consult with your plan administrator to determine if your plan is governed by ERISA.
- If your plan is governed by ERISA, you may have the right to bring a civil action, under ERISA *Section 502(a)(I)(B)*. This right can be exercised after all required reviews of your claims, including the appeal process, have been completed; your claim was not approved, in whole or in part; and you disagree with the outcome of the resolution.

Under ERISA, you are entitled to receive, on request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to your claim for benefits. On request, you may receive, free of charge, a copy of the medical necessity benefit determination, as well as any guidelines that were used in making this determination.

You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency.

The participating Provider may not bill the Member for care or services denied for payment on the basis of medical necessity, unless the Member signs a waiver letter (separate from any waiver information on any admission form) accepting liability during his or her stay, for services denied prospectively or days of acute care beyond those approved as Medically Necessary. See the *Member (Patient) Responsibility Agreement* in the *Exhibits* section of this Manual.

Prompt notification of an Anthem Member's admission, proactive discharge planning and effective communication between the Provider, Anthem, and clinical staff ensure that medically inappropriate days are avoided and minimize the financial liability risk for denied days.

Member's Liability

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

1. Facility services not covered by the Member's Benefit Agreement. However, for health services that are not Medically Necessary or are experimental/investigational see Number 3 below.
2. Copayments, coinsurance and deductible amounts required by the Member's Benefit Agreement, as long as Customer Service has been contacted to verify the Member's responsibility (i.e., whether or not the Member has satisfied his or her respective deductible).

3. Health services that are not Medically Necessary, but agreed to by the Member in advance, in writing, on a waiver form (also called the *Member (Patient) Responsibility Agreement)* approved by Anthem Blue Cross, which informs the Member that the services are likely not to be deemed Medically Necessary or are likely to be non-covered due to being experimental or investigational, and which includes an estimate of the cost of the services to which the Member is agreeing to pay. A sample of the Member (Patient) Responsibility Agreement can be found in the Exhibits section of this Manual.

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

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

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

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

BlueCard® Program

For information specific to the BlueCard see section *BlueCard® Program* and the BlueCard Provider Manual, online at anthem.com/ca > scroll to the bottom of the page, select Providers > Enter > Communications > BlueCard® Program Provider Manual.

Federal Employees Health Benefits Program

For information specific to Federal Employee Program (FEP) see section *Federal Employees Health Benefits Program* (FEHBP) of this Manual.

Medicare Advantage

For information on Medicare Advantage, refer to the *Medicare Advantage* section of this Manual.

Pharmacy Prior Authorization & Grievance and Appeal Process

Member and Practitioner Notice

When a drug is denied at point-of-sale due to a specific exclusion in the Member's pharmacy benefit, or prior authorization is required for a specific medication, the dispensing pharmacy receives an electronic message indicating the reason for the denial.

If the reason for denial is that the drug requires prior authorization of benefits (PAB), the dispensing pharmacist will call the prescribing physician to initiate the Prior Authorization process. The prescribing physician will FAX the completed Prior Authorization request form to Anthem for review. If the

predetermined medical criteria are met, an authorization is entered, and notification is sent to the prescribing physician and the Member.

If additional medical information is needed the request will be sent back to the prescribing physician, requesting submission of the original form and all pertinent additional medical information to Anthem for additional review.

The CRC will approve the request if the additional information meets the predetermined medical criteria. If the predetermined medical criteria are not met, the Anthem physician advisor will deny the request. The reason for denial and the name of the Anthem physician advisor will be included in the denial letter that is sent to the Member and requesting physician.

If the decision made by the CRC unit or the Anthem physician advisor is unacceptable to the Member, he or she may appeal the decision. The appeal is forwarded to the G&A Department for handling through the standard or expedited appeal process as appropriate to the clinical issue.

The Member or his/her physician may provide additional medical information in the appeal of a denied medication. An Anthem medical director, who did not participate in the initial determination and is not a subordinate of the previous reviewer, is responsible for the final determination on a pharmacy appeal. The medical director arrives at a decision, based on the specific medical criteria requirements for medical necessity, or directs that a physician advisor specialist in the same or similar specialty that typically manages the condition, review the case, prior to issuing an adverse determination.

Appeal Rights Notice to Members and Providers on Adverse Pharmacy Determinations

When a final decision is made regarding a requested medication, the Member is sent written notification of this determination. If the reason for denial is due to a contractual exclusion, the Member is provided this information, as well as the EOC information pertaining to his or her specific request. If the decision is to uphold the denial due to lack of medical necessity, the Member is sent a letter advising him or her of the denial, with information regarding the Member's appeal rights for IMR (AB 55), arbitration and DMHC/CDI information.

If the final determination made regarding a previously denied medication is to allow coverage of a medication, a designated associate will load the required authorization into the system to allow the Member to obtain the requested medication through their pharmacy benefits.

If the grievance pertains to an issue not related to the denial of a medication, the Member will be sent a letter advising of the final outcome of their grievance issue. This may be a letter informing the Member how his or her copayments and/or deductible were calculated, or simply providing general information and policy regarding vacation supplies, early refills, etc.

Appeal reports, including pharmacy appeals, are provided to Anthem's executive team for analysis, tracking, trending, and quarterly reporting to the Anthem Quality Management Committee.

Off-Label Prescription Drug Coverage

Health & Safety Code, Section 1367.21 prohibits health care service plans from limiting or excluding coverage of off-label prescription drugs for treating a chronic and seriously debilitating condition, defined as a condition that requires ongoing treatment to maintain remission or prevent deterioration and significant long-term morbidity. The drug must meet the following conditions:

- The drug is approved by the FDA.
- The drug is either:

1. Prescribed by a participating physician for a “life-threatening condition”; or
2. Prescribed by a participating physician for a “chronic and seriously debilitating condition,” Medically Necessary to treat that condition, and on the plan formulary. If the drug is not on the formulary, the exceptions process required must be implemented.

The drug is recognized for treatment by the American Medical Association’s *Drug Evaluations;* the *American Hospital Formulary Service Drug Information,* the *U.S. Pharmacopoeia Dispensing Information,* Volume 1; or two articles from major peer-reviewed journals that have undisputed data supporting the proposed use as safe.

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Information for Contracted Providers

The Department of Managed Health Care (DMHC) promulgated regulations known as the Claims Settlement Practices and Dispute Resolution Mechanism Regulations (Claims and Dispute Regulations), which can be found in *Title 28* of the *California Code of Regulations, Sections 1300.71* and *1300.71.38*. These regulations require that Anthem Blue Cross and its Providers establish a fast, fair and cost-effective dispute resolution mechanism to process and resolve contracted and non-contracted Provider disputes. The Federal Employee Program (FEP) is not within the jurisdiction of the DMHC. FEP is governed by Federal regulations.

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

Dispute Resolution Process for Contracted Providers

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

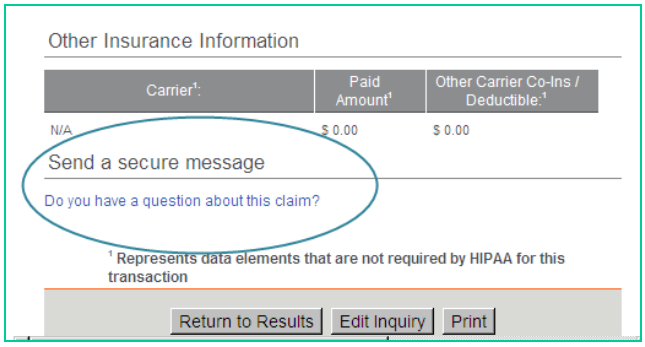
2. Secure Messaging – Availity Web Portal (Availity). The Availity Web Portal provides the opportunity to "ask a question" about a claim online. You can send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is a feature accessed at availity.com. This functionality is only available on the Availity Web Portal. Secure messages can be sent for local Anthem, Anthem Blue Cross Blue Shield, BlueCard® out-of-area, and FEP (Federal Employee Program) Member claims.

   ! Note: If you received a bar-coded mail-back letter regarding a claim, do not use Secure messaging to respond. Instead place the mail-back letter on top of the requested information and follow mailing instructions.

   How do I send a Secure Message?

   To send a secure message:

   - Select the link "Do you have a question about this claim?"



     ! Note: This option will only appear if your organization's Administrator has set up your account to include Secure Messaging.

   - Once this link is selected, a new window will open and you will choose one of the seven questions from a dropdown box and use the free-form text box to add any detailed additional information related to your question and Select "submit." You will receive an Inquiry Control Number (ICN), which confirms your Secure Message has been sent and received.

   How are Secure Messages processed?

   - Your secure message is routed to Anthem Customer Service departments for a response through the secure messaging system, eliminating the need for you to make a phone call for the same information.
   - If you have additional questions on a claim based on the response, you can reply to Customer Service's response with further questions.
   - Messages are stored within the Secure Messaging tool, accessed under the Claims menu option on the Availity Web Portal, in the Inbox and Outbox. You can review messages you previously sent, view new responses received, and save messages to your computer or print for your records.

- Secure Messages are housed within a self-contained, secure email system, separate from your office email account. The messages are sent and received using your login credentials for the Availity Web Portal.

Secure Messaging should be used when you need to:

a. Inquire on the status of a claim
b. Have a billing/claim reimbursement question
c. Need to submit proof of timely filing
d. Request for retraction related to Third Party Liability or Worker's Compensation
e. Ask why the claim was processed incorrectly; provide reasons

3. Sending a Contracted Provider Dispute to Anthem. Each contracted Provider dispute submitted to Anthem must include the information listed. The *Provider Dispute Resolution Request* form is available in the *Exhibits* section of this Manual, on anthem.com/ca, or by calling the Customer Service number referenced on the Member's identification card.

   Contracted Provider disputes must be sent to the following address:

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

4. Time Period for Submission of Provider Disputes:
   a. Contracted Provider disputes must be received by Anthem no later than 365 days from the Anthem' action that first led to the dispute; or
   b. In the case of inaction, contracted Provider disputes must be received by Anthem no later than 365 days after the Provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
   c. Contracted Provider disputes that do not include all required information as set forth above may be returned to the submitter for completion. An amended contracted Provider dispute, which includes the missing information, shall be submitted to Anthem within 30 working days of the returned receipt date.

5. Acknowledgment of Contracted Provider Disputes.

   Anthem will acknowledge receipt of all contracted Provider disputes within 15 working days of the date of receipt.

6. Contact Anthem Blue Cross Regarding Contracted Provider Disputes. All inquiries regarding the status of a contracted Provider dispute or information about filing a contracted Provider dispute must be directed to Anthem by "Type of Plan" at the telephone numbers listed in the "Claims and Correspondence Mailing Address" subsection of the *Directory of Services*.

7. Instructions for Filing Substantially Similar Multiple Contracted Provider Disputes. You can use the *Provider Dispute Resolution Request* form available on anthem.com/ca or call the Anthem Customer Service number referenced on the Member's identification card to address substantially similar multiple contracted Provider claims, billing or contractual disputes.

These disputes may be filed in batches as a single dispute, provided that they are submitted in the following ways:

a. Sort Provider disputes by similar issue
b. Provide cover sheet for each batch
c. Number each cover sheet
d. Provide a cover letter for the entire submission describing each Provider dispute, with references to the numbered cover sheets

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

Following the Provider Dispute Resolution Process, if you continue to disagree with Anthem's decision, you may request a meet and confer, and then, if necessary, arbitration, pursuant to your Agreement and the below *Meet and Confer* subsection.

Meet and Confer

All Provider disputes must be submitted to, and processed through, the Provider Dispute Resolution Process prior to requesting a meet and confer. Unless your Facility Agreement provides otherwise, the following procedures are applicable to all meet and confer requests submitted to Anthem Blue Cross on or after the effective date of this Facility Manual.

Submit requests for a meet and confer to the following address:

Legal Department
Attn: Meet and Confer Request
Anthem Blue Cross
21555 Oxnard Street, AC1C
Mailstop CAAC01-001B
Woodland Hills, CA 91367

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

The party requesting the meet and confer (Requesting Party) shall provide all documentation and materials upon which it bases its position. Any meet and confer request made by the Facility shall, at a minimum,

contain the following information related to each Member that is the subject of the meet and confer request: (1) Member's name, (2) Member's Anthem identification number, (3) applicable date(s) of service, (4) a copy of the written determination that was made by Anthem on the dispute when it was submitted to

the Anthem Provider Dispute Resolution process, (5) the Provider's expected reimbursement amount, (6) the manner in which the expected reimbursement amount was calculated by the Provider and (7) an explanation as to why the Provider disagrees with the Member claim determination made by Anthem during the Provider Dispute Resolution Process.

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

Medical Necessity – The Member's complete medical records for the date(s) of service in dispute.

Note that certain Facility Agreements provide that medical necessity disputes (length of stay, level of care, and/or whether the service is investigational/experimental) are to be handled through a binding determination to be made by an Independent Review Organization (IRO), in lieu of a meet and confer and/or arbitration. If your Agreement includes this provision, then do not request a meet and confer over a medical necessity dispute.

Timely Filing – If a claim was denied based upon an alleged failure to timely submit a claim, written proof, in the form(s) set forth in the section entitled *Claims Submission*, subsection "Claim Submission Filing Limit," and in the *Exhibits* section of this Manual entitled *Timely Filing Acceptable Forms of Proof* that the claim was timely filed.

Lack of Authorization – If a claim was denied based upon a lack of authorization, written proof of authorization.

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

24-Hour/Midnight Rule – If your Facility Agreement includes the 24-hour or midnight rule and there is a dispute over whether a patient claim was to be paid at the inpatient or outpatient rate, written documentation showing the date and time the patient was admitted and discharged from the Facility.

Subject to any limitations that may be set forth in the Facility's Agreement with Anthem, for purposes of the meet and confer, multiple claims may be "batched" or presented in the same manner described previously in the subsection entitled *Instructions for Filing Substantially Similar Multiple Contracted Provider Disputes*. However, claims may only be batched upon behalf of one Requesting Party.

Except for medical necessity disputes where the Facility and Anthem have agreed to resolve such disputes through the binding IRO process, if satisfactory resolution is still is not reached through the meet and confer process, the Facility agrees to arbitrate the dispute, as set forth in the Facility's Agreement. The Facility may only commence arbitration after the dispute has been submitted to both the *Provider Dispute Resolution Process* and then the *Meet and Confer Process.* The Provider Dispute Resolution Process and the Meet and Confer Process shall not toll the running of the applicable statute of limitations for filing an arbitration demand. Therefore, the Facility is strongly encouraged to engage in the Provider Dispute Resolution Process and Meet and Confer Process in a timely manner.

Independent Review Organization Dispute Resolution Process for Medical Necessity Disputes

Certain Facilities have an Agreement with Anthem Blue Cross that requires that all medical necessity disputes (length of stay, level of care, or whether a procedure is investigational/experimental) are to be resolved through a binding determination to be made by an IRO. If your Agreement with Anthem Blue Cross contains this dispute resolution provision and the claim involves one where Anthem Blue Cross performs the utilization management and Provider appeal/Provider dispute resolution function for the claim in dispute, you are still required to first submit the dispute through an appeal made in accordance with the Provider Dispute Resolution Process described above. If you are not satisfied with the outcome of the Provider Dispute Resolution Process, do not submit the dispute to the meet and confer process. Further, if your Agreement with Anthem Blue Cross contains this dispute resolution provision, you may not submit medical necessity disputes for those claims to arbitration. Instead, for all medical necessity disputes for those claims, the Facility shall adhere to the Process below for a binding, final resolution of the dispute to be made by an IRO. If the claim in dispute is not one where Anthem Blue Cross performs the Utilization Management and Provider appeal/Provider dispute resolution functions, then this IRO process does not apply.

1. For each disputed medical necessity claim where Anthem Blue Cross performs the Utilization Management and Provider appeal/Provider dispute resolution function for the claim in dispute, the Facility shall complete and submit to Anthem Blue Cross a Facility Binding *Independent Review Organization (IRO) Request* form. The form must be completed in its entirety. Copies of the form can be found in the *Exhibits* section of this Manual or online at ProviderAccess;
2. The completed form shall be mailed to: Anthem Blue Cross, Risk Unit AC-5I, P.O. Box 60007, Los Angeles, California 90060-0007;
3. A separate form must be completed and submitted for each disputed medical necessity claim;
4. The Facility may select one IRO to be used from a list of two or more IROs that Anthem Blue Cross will identify on the *IRO Request* form;
5. All submissions made pursuant to this section shall be made within the timeframe set forth in your Agreement with Anthem. If no timeframe is set forth in your Agreement with Anthem, then the submission of a medical necessity dispute to the IRO process shall be made no later than 365 days following an adverse determination made by Anthem Blue Cross in the Provider Dispute Resolution process;
6. Once an IRO Request is submitted, Anthem Blue Cross will submit the Request, along with all medical records previously submitted by the Facility to Anthem Blue Cross, to the IRO designated by the Facility. The Facility may not submit additional medical records in conjunction with the IRO Request. It is expected that all medical records necessary for Anthem Blue Cross to make a medical necessity determination would have been submitted by the Facility no later than its appeal to Anthem Blue Cross in the Provider Dispute Resolution Process;
7. When the designated IRO makes its determination, copies of the written determination will be transmitted to both Anthem Blue Cross and the Facility;
8. If the IRO rules either in whole, or in part, in favor of the Facility, Anthem Blue Cross will directly adjust and pay the claim through its claims system in accordance with the determination made by the IRO.

9. Unless your Agreement with Anthem Blue Cross provides otherwise, the cost of the IRO shall be equally divided between Anthem Blue Cross and the Facility.

Dispute Resolution and Arbitration

The substantive rights and obligations of Anthem Blue Cross and the Facility with respect to resolving disputes are set forth in the Agreement. 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. The following procedures and processes are applicable to all arbitrations and mediations commenced on or after the effective date of this Facility Manual.

A. Cost of Non-binding Mediation. The cost of the non-binding mediation will be shared equally between the parties, except that each party shall bear their own respective attorneys' fees.

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 this Agreement is located except to the extent both parties agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s). If the total amount in dispute is less than $2,000,000, exclusive of interest, costs and attorneys' fees, the dispute shall be decided by a single arbitrator selected in the manner described in the JAMS Comprehensive Arbitration Rules and Procedures. If the total amount in dispute is $2,000,000 or more, exclusive of interest, costs and attorneys' fees, the dispute shall be decided by an arbitration panel consisting of three arbitrators, unless the parties agree in writing that the dispute shall be decided by a single arbitrator. The arbitration panel shall consist of one (1) arbitrator selected by the Facility (Provider), one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. In the event that any arbitrator withdraws from, or is unable to continue with, the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery. The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties' goals in providing for disputes to be 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, 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.

E. 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. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Facility's Agreement with Anthem and shall be bound by and follow controlling law, including, but not limited to, any applicable statute of limitations, which shall not be tolled or modified by the procedures set forth in this Manual. 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. The cost of any arbitration proceeding under this section shall be

shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s); provided, however, that the arbitrator(s) may not require one party to pay all or part of the other party's attorneys' fees. 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 Blue Cross is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

F. Confidentiality. 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 or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained.

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Introduction

The following summaries describe a broad variety of Anthem Blue Cross and/or Anthem Blue Cross Life and Health Insurance Company managed care products, enhancements and benefits, including preferred Provider organization (PPO), health maintenance organization (HMO), point-of-service (POS), behavioral health, pharmacy and Workers' Compensation products. Many of these products are optional and may be purchased separately. They are listed below in alphabetical order.

24/7 NurseLine

24/7 NurseLine is a toll-free medical information line. It gives Members access to a specially trained registered nurse (under physician supervision) who may help with health care questions or concerns, 24 hours a day. Callers are led through a computer-based, over-the-phone protocol of questions to determine the caller's risk category and an appropriate course of action. This could range from self-care in routine cases, to calling 911 in life-threatening situations. 24/7 NurseLine also includes a vast library of informational tapes covering more than 200 medical topics.

Anthem Blue Cross Life and Health PPO

Anthem Blue Cross Life and Health Insurance Company offers PPO plans utilizing the Prudent Buyer network. The *Anthem Blue Cross Life and Health PPO* plans are regulated by the California Department of Insurance (CDI). Among the PPO plans are high deductible plans that are designed to work with Health Reimbursement Accounts (HRA) or plans, which work with Health Savings Accounts (HSA). Depending on their employer, Members can choose from one or more of the following options.

Lumenos HSA

Whether through employer contributions or a Member's own pre-tax money, the Lumenos Health Savings Account will help pay for future health expenses and build savings for retirement.

Lumenos HRA

An employer allocates funds to a Member's Health Reimbursement Account without spending anything out of pocket first. Unused funds can be used to help reduce future out-of-pocket costs.

Lumenos HIA PLUS

Members use the allocation to their Health Incentive Account Plus without spending anything out of pocket first. Members can save funds they don't use to help reduce future out-of-pocket costs.

Lumenos HIA

By completing a health assessment or engaging with a personal coach, Members can earn extra dollars through the Healthy Rewards program for a Health Incentive Account that helps offset future out-of-pocket costs for medical care and prescriptions.

Anthem Blue Cross Life and Health TONIK Plans

Anthem Blue Cross Life and Health Insurance Company has plans geared specifically toward active, young, healthy people who need health insurance, but hate forms and insurance jargon. These plans are called TONIK, are easy to understand and are very affordable. New Members can enroll online or with an agent. TONIK plans are PPO plans, so the Member is able to choose his or her physician(s). For more information call the toll-free number 1-866-333-4820.

Behavioral Health Program

Behavioral health is an integrated part of the Anthem medical product line. Members have access to psychiatrists and therapists, as well as Facilities and Hospitals, offering an array of services ranging from individual outpatient care to acute psychiatric hospitalization.

BlueCard® Program

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

Blue Cross HMO

Blue Cross HMO is a health maintenance organization (HMO) designed to support Members' efforts to stay well and provide them convenient access to the most appropriate and cost-effective quality health care. Each Member enrolled in Blue Cross HMO chooses a primary care physician (PCP) who is responsible for coordinating health care services for that Member.

Blue Cross POS

Blue Cross POS is a point-of-service plan that provides Members in minimum-sized groups with the option of selecting services from the Blue Cross HMO Plan, the Blue Cross PPO Plan or out-of-network Providers.

Blue Cross PPO

The Blue Cross PPO (Prudent Buyer Plan®) is a preferred Provider organization (PPO) that includes PCPs, a wide variety of specialists and Hospital-based physicians. The Blue Cross PPO Plan offers Members the ability to choose more than one physician from the network, depending on the services required. Members may self-refer to any physician in the network. Benefit plans are designed with financial incentives for Members to use Providers in the PPO Plan network.

Blue Cross Preferred HMO

Blue Cross Preferred HMO combines the benefits of Blue Cross HMO with the flexibility of the Blue Cross PPO Plan, providing Members with access to both HMO and PPO Provider networks. Members can receive care from their selected Anthem HMO participating medical group (PMG)/independent practice association (IPA), or they can choose to see an Anthem Blue Cross PPO Plan Provider, without a referral, for a limited number of outpatient and professional services that are separate from the Anthem HMO benefits.

Blue Cross Select PPO

The Select PPO network is a statewide network made up of primary and specialty care physicians/physician groups that currently participate in our Prudent Buyer PPO network. Physician and physician groups were selected to participate based on clinically efficient health care practices. Physicians and physician groups were also selected based on network need. All selected physicians were screened using broadly accepted quality measurement standards.

This network will maintain current reimbursement levels as well as operating procedure and referrals. The plans in this network will offer comprehensive medical services and will generally utilize existing Hospital and ancillary network relationships.

Employee Assistance Program

Anthem also offers an Employee Assistance Program (EAP) that provides confidential, professional assistance. The EAP is an opportunity for Members to address a variety of personal concerns, such as family or relationship difficulties, substance abuse, career concerns, legal and financial problems, or other stress-related and emotional problems.

Federal Employee Program (FEP)

To access FEP information, refer to their website: fepblue.org.

Future Moms

Future Moms is a perinatal program offered to Anthem HMO and PPO Members. The program is designed to promote early and regular prenatal care so that our Members experience a healthy pregnancy and healthy baby. Specialized nurse health coaches work with Members to create a pregnancy program that is tailored to their lifestyle, home environment and specific needs. Anthem Members can enroll into the program by contacting Future Moms toll-free number at 1-800-769-4896.

Health and Wellness

Health and Wellness offers a wide-ranging suite of programs, services and tools, including preventive care, wellness information, disease management and Case Management services. These programs help Members and their physicians manage chronic illnesses through education and monitoring. The goal of

Health and Wellness is to help improve the quality of life of Anthem Blue Cross (Anthem) Members through education and, in the process, help reduce health care utilization and increase Member satisfaction. Currently, Anthem ConditionCare programs (disease management) for asthma, chronic obstructive pulmonary disease (COPD), congestive heart failure (CHF), coronary artery disease (CAD) and diabetes.

Heath and Wellness augments and supports the care the Member receives from his or her physician by providing a three-way relationship between the Member, the physician and Anthem.

For more information, refer to the *Health and Wellness* section of this Manual.

HMO-USA

HMO-USA is a nationwide network of Blue Cross and Blue Shield Plan HMOs (participating plans) sponsored by the Blue Cross and Blue Shield Association (BCBSA). BCBSA participating plan HMOs have agreements to provide each other's Members with guest memberships, urgent and emergency care, routine care, and follow-up care as pre-approved and authorized by Anthem when the Member is traveling away from his or her home HMO-USA participating plan.

PPO (non-California resident)

PPO plans are offered by *Anthem Blue Cross Life and Health Insurance Company* to California-based companies who have employees who live, either permanently or temporarily, outside California. PPO plans are preferred Provider plans using the Blue Cross and/or Blue Shield plans' networks of Providers.

Prescription Drug Program

The Prescription Drug Program is a complete package of services, including Utilization Management, Member education, disease state management, monitoring prescription drug trends, clinical program development and administrative processing service capabilities, that are all designed to offer comprehensive, quality services to Members.

SpecialOffers

SpecialOffers is a program that provides Anthem Members information about a wide range of products and services, available at a discount, to help them meet their individual health, fitness and wellness goals. Members can take advantage of discounts ranging from five to 60 percent on a variety of wellness products and services from participating vendors.

On the Anthem website, anthem.com/ca, select "SpecialOffers" to find information on the program. The vendors that offer discounts through the programs are listed under the following categories:

- Family & Home
- Fitness & Health
- Vision, Hearing & Dental
- Medicine & Treatment

The products and services offered under SpecialOffers are not covered benefits under the Member's health plan.

Workers' Compensation Services

Anthem Workers' Compensation (AWC) is a specialty business unit marketed under Anthem Workers' Compensation, LLC. AWC focuses on integrating group health and Workers' Compensation. This approach allows employees and Members to use the same network for both occupational and nonoccupational treatment. AWC currently provides network access, PPO bill pricing and Medical Provider Network (MPN) services to insurance companies, third-party administrators and self-insured employers, and managed care companies in California. If you would like to contact our AWC department, call our Customer Relations toll-free number 1-866-700-2168.

Medicare Crossover

Duplicate Claims Handling for Medicare Crossover.....2

Duplicate Claims Handling for Medicare Crossover

Since January 1, 2006, all Blue Plans have been 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 to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its 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.

Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 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

If Provider or Facility provides Members' Blue Plan ID numbers when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 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 30 additional calendar days for Provider or Facility to receive payment or instructions from the Blue Plan.

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

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

Effective October 13, 2013, we will reject Medicare primary Provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 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 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 your 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.

Effective October 13, 2013:

- 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, our Members will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Member.

Providers and Facilities can call the E-Solutions Help Desk toll-free number at 1-800-470-9630, or go to the www.anthem.com/EDI webpage to request assistance with submitting electronic Claims to us. If you have any questions about where to file your Claim, contact the Provider Customer Service phone number on the back of the Member's ID card.

Medicare Advantage

Medicare Advantage Provider Website 2
Medicare Advantage HMO and PPO Provider Guidebook 2

Medicare Advantage Provider Website

! In this version of the Manual, for information on Medicare Advantage, refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook.

Medicare Advantage HMO and PPO Provider Guidebook

Links to the Medicare Advantage Provider Manuals are located on the Medicare Advantage page referenced above, including the Medicare Advantage HMO & PPO Provider Guidebook.

Federal Employees Health Benefits Program

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Federal Employees Health Benefits Program Requirements

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

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

Submission of Claims

All claims under the FEHBP must be submitted to Plan for payment within one hundred fifty (150) calendar days 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 one hundred fifty (150) calendar day period 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 this one hundred fifty (150) calendar day period. 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.

Erroneous or Duplicate Claim Payments

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 with 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

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.

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 otherwise, the Provider or Facility will be responsible for the cost of services denied.

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 problems as an alternative to legal actions.

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

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

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

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

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

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 written within 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 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the claim. If the additional information is not received within 60 calendar days, the 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.

Eligibility

Anthem Blue Cross does not determine the eligibility of federal employees. It is the responsibility of the United States government's employing offices to determine Members' eligibility for enrollment and, through the Members' payroll offices, to notify the FEP Operations Center of enrollment status changes and effective dates. The employing office is responsible for making decisions about which family Members are eligible for coverage. It is the responsibility of the U.S. Office of Personnel Management (OPM) to establish regulations governing a federal employee's eligibility to enroll, and OPM sets the conditions under which the employee can change enrollment. OPM functions as the employment office for retired federal employees and, as such, performs the payroll and personnel office functions for federal retirees and survivor annuitants.

Eligibility for FEP Members may be determined through the Availity Web Portal or by telephoning the FEP customer service Provider Line at the toll-free number 1-800-322-7319.

All FEP claims require the alpha prefix "R" in the subscriber ID code when electronic claims are transmitted to FEP for payment consideration. The correct FEP subscriber ID number identifies the subscriber and all of his or her covered dependent(s) in the Anthem Blue Cross system. FEP can be contacted as follows:

Anthem Blue Cross
FEP Customer Service
P.O. Box 105557
Atlanta, GA 30348-5557

The FEP Customer Service telephone is toll-free at 1-800-322-7319.

Federal Employee Program (FEP): Medicare as Primary

Electronic claims are automatically crossed over to the FEP system from Medicare, when Medicare is billed as the primary payor. To submit a Medicare/FEP crossover claim, the payor information must be reported on the claim, and should include the actual FEP subscriber ID and the actual FEP group number in their respective fields.

Overpayment Recovery Process

The following process applies to institutional claims for FEP:

Notification will be mailed to you 60 days prior to initiating any overpayment recovery efforts (this does not apply to Hospitals that have Special Payment Arrangements)

If payment is not received within 60 days, recovery of the overpayment amount will be taken off of future claims payments.

In cases where Anthem Blue Cross determines that clipping (taking the amount off of future claim payments) is not feasible or Providers Contract does not allow, then FEP Recovery Letter's will go out.

If a check for the overpayment has still not been received, the overpayment is referred to a collection service.

The Provider has 30 days from the date of the notification to appeal, or inform us that the funds have already been repaid.

For erroneous or duplicate claim payments under the FEP, 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.

If you have been overpaid and wish to return the payment:

Contact FEP customer service at the toll-free number 1-800-322-7319. You may either send payment to us at: Central Region-CCOA Lockbox, P.O. BOX 73651, Cleveland, OH 44193-1177, or request that we recover the overpayment on an upcoming remittance. Include a copy of the refund request letter if one had been sent to you, when sending your refund.

Appeal Process for overpayment recoveries:

If you wish to appeal an FEP overpayment recovery, or have any questions about the overpayment recovery process, contact Customer Service at the toll-free number 1-800-322-7319 or you can mail a written notice to us at P.O. BOX 105557, Atlanta, GA 30348-5557.

Federal Employee Health Benefits Program Medicare Equivalent Amount

The following information applies to Members who:

1. Are not covered by either Medicare Part A (Hospital insurance) or Part B (medical insurance), or both;
2. Are enrolled in the Blue Cross and Blue Shield plan as an annuitant, or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse; and
3. Are not employed in a position that confers Federal Employee Program Health Benefit coverage.

If the Member not covered by Medicare Part A, is of age 65 or older (or becomes age 65 while receiving inpatient Hospital services), retired and receives care in a Medicare-participating Hospital, the law (5 U.S.C. 8904[b]) requires the Blue Cross and Blue Shield plan to base payment on an amount equivalent to the amount Medicare would have allowed if the Member had Medicare Part A. This amount is called the equivalent Medicare amount. After the Blue Cross and Blue Shield Plan pays, the law prohibits the Hospital from charging the Member more for Covered Services than any deductibles, coinsurance or copayment owed by the Member under the Blue Cross and Blue Shield Plan.

Any coinsurance the Member owes will be based on the equivalent Medicare amount, not the actual charge. Additional information and assistance is available by calling the FEP Customer Service Provider Line at the toll-free number 1-800-322-7319.

About the Blue Cross and Blue Shield Service Benefit Plan

The local Blue Cross and Blue Shield Plans underwrite and administer the BlueCross and BlueShield Service Benefit Plan, the largest privately underwritten health insurance contract under the Federal Employee Health Benefits (FEHB) Program. Sixty two percent of all federal employees and retirees who receive their health care benefits through the government's FEHB Program are Members of the Service Benefit Plan.

1. Anthem Blue Cross, FEP Customer Service can be reached at the toll-free number 1-800-322-7319.
2. Blue Shield of California FEP UM can be reached at the toll-free number 1-800-633-4581.
3. Blue Shield of California FEP CM can be reached at the toll-free number 1-800-995-2800.

Access the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure through our website: fepblue.org.

Federal Employee Program (FEP) Preferred Providers include Blue Shield's Preferred Physicians, Participating Providers and Blue Cross' Preferred Hospitals. FEP Members may select the Basic Option or Standard Option benefit level. Under the Standard Option, Members can seek care from any covered Provider they want, however, in some cases, they must get advance approval of care from Blue Shield. Under the Basic Option, Members must use preferred Providers in order to receive benefits, except under the following special circumstances:

- Medical emergency or accidental injury care in a Hospital emergency room and related ambulance

- transport (as described in Section 5(d) of the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure for emergency services and accidents)
- Professional care provided at preferred Facilities by non-preferred radiologists, anesthesiologists, certified registered nurse anesthetists (CRNAs), pathologists, emergency room physicians and assistant surgeons
- Laboratory and pathology services, X-rays and diagnostic tests billed by non-preferred laboratories, radiologists and outpatient Facilities
- Services of assistant surgeons
- Special Provider access situations
- Care received outside the United States and Puerto Rico

Unless otherwise noted above, when services of non-preferred Providers are covered in a special exception, benefits will be provided based on the plan allowance. Members are responsible for the applicable coinsurance or copayment, and may be responsible for any difference between Anthem Blue Cross or Blue Shield's allowance and the billed amount (refer to section 3 of the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure for more information on special circumstances).

Pre-certification for Inpatient Hospital Admissions for FEP

Preferred Providers are responsible for obtaining pre-certification for all inpatient admissions to preferred Hospitals. Pre-certification requires notification prior to scheduled admissions or within two business days after an emergency admission. The Member will be subject to the $500 benefit reduction if admitted to a preferred Hospital and pre-certification is not obtained. The Members ultimately responsible for ensuring that pre-certification has been completed. If the pre-certification is not obtained, the Member's inpatient Hospital benefit for Covered Services will be reduced by $500 (for specific rules, refer to section 3 the Blue Cross and Blue Shield Service Benefit Plan Contract Brochure). Pre-certification is not needed for a maternity admission for a routine delivery. However, if medical condition requires a stay more than 48 hours after a vaginal delivery or 96 hours after a cesarean section, then Provider must contact us for precertification of additional days. Further, if the baby stays after the mother is discharged, then the physician must contact Blue Shield for pre-certification of additional days for the baby.

Mental Health, Substance Abuse, and Behavioral Health Services

No prior authorization for professional services, including individual or group therapy, outpatient partial hospitalizations, intensive outpatient programs, office and home visits, pharmacotherapy (medication management), or psychological testing, is necessary for FEP PPO Members.

Prior authorization is only necessary for inpatient Hospital stays. In the event of an emergency, notification of hospitalization must be received by the plan within 48 hours after any admission or the next occurring non-holiday weekday, whichever is later.

It is important to follow these policies to help ensure your patient's needs for mental health and substance abuse services are met efficiently. Use the following information to request assistance:

For any services that are to be rendered in a residential treatment center (RTC), call the toll-free number 1-800-995-2800 before services are rendered. Services in a RTC are not a covered benefit. A case manager will be able to assist you and the Member to assess other options and to locate a preferred Provider to assist in any additional services the Member may require.

For Behavioral Health Inpatient Hospitalizations call the toll-free number 1-800-633-4581.

For questions about the FEP prior authorization requirements, call FEP Customer Services at the toll-free number 1-800-322-7319.

Integrated Case Management Program for FEP

Nurses who are licensed and familiar with California resources will be assisting your patients with obtaining the resources they require to maintain their optimum health. The referral phone number is the toll-free number 1-800-995-2800.

Our Integrated Case Management program offers a systematic application of processes and shared information to optimize the design and coordination of benefits and care for Members identified with acute or complex conditions. Through comprehensive, high-touch, coordinated care management delivered in partnership with Providers, clients, and Members, the program promotes improved health outcomes, quality of life, and Member satisfaction.

Conditions managed through our Integrated Case Management Program include:

Acute Catastrophic. Includes Members with immediate needs relating to an acute episode of care for conditions such as stroke, septicemia, spinal cord injury, trauma, amputation, open wounds, newly diagnosed cancer, or complications from surgeries characterized by readmission to the Hospital.

Chronic-Complex. Focuses on patients with advanced chronic diseases with high co-morbidity, but with less clinical severity and fewer management needs than patients in the onsite High-Risk Complex Case Management program.

Chronic High-Risk. Focuses on Members with chronic, long-term conditions that require ongoing medical attention and/or limit activities of daily living, such as chronic pain, musculoskeletal conditions, chronic respiratory conditions with ventilator or oxygen dependence, diabetes, heart disease, HIV, terminal illnesses, dementia and other cognitive impairment disorders, and developmental disabilities.

End-Stage Renal Disease (ESRD). Involves Members needing coordination of care related to dialysis, home care and/or transplant.

Post-neonatal Intensive Care Unit (NICU)/Pediatrics. Focuses on premature or medically complex neonates being discharged home from the Hospital after birth, as well as pediatric Members with special needs.

Behavioral Health. Assists Members with Mental Health and Chemical Dependency diagnosis. Participates in discharge planning for all inpatient psychiatric and substance abuse admissions, including detoxification.

Oncology. Focuses on Members with cancer diagnosis to manage them through the health care continuum.

Palliative Care. Provides a care management option for patients that include symptom control in addition to curative therapy. A combination of palliative care while curative care is ongoing has been

shown to improve quality of life, reduce inpatient stays, increase choice of hospice and the results have been demonstrated in both a care delivery locus and in a health plan setting. The intent of the program is to permit the use of palliative care, for severe chronic conditions one year in advance of the patient's likely end of life.

Transitions of Care Program

Blue Shield's Transitions of Care program focuses on Members and caregivers who need guidance on the transition to and from Hospital and home. Unplanned readmissions are prevented by completing a safety risk assessment with the Member, discussing follow-up plans, medication reconciliation, and facilitating adherence to the prescribed treatment plan. Length of Hospital stay is decreased by preparing Member for Hospital stay and development of a discharge plan. The referral phone number is a toll-free number at 1-800-995-2800.

The Transitions of Care program has four primary components:

- A telephone call to the Member by a Transitions of Care Nurse (TCN) to discuss the surgery/acute condition, what to expect, what to ask their physician, and how to prepare for the return home.
- A complimentary Guided Imagery Toolkit mailed to Members prior to or following surgery that contains an instructional letter and an audio tape or compact disc of recordings that weave together inspirational music, healing images, and positive statements to help add to a Member's sense of safety and comfort prior to and following surgery.
- A recovery guide that provides Members with useful information regarding what to ask their physician such as pre- and post-operative testing and preparation, expected post-operative recovery milestones, and information regarding return to work.
- A post-hospitalization call to identified patients who are urgently or emergently admitted to an acute care Hospital. The TCN will discuss adherence to the discharge plan, provide medication reconciliation, and conduct a needs assessment for any unmet needs the patient may have post discharge. Additionally, the TCN may engage in care coordination efforts with the Member when any unmet needs have been identified that may need further intervention.

Below is the Anthem Blue Cross and Blue Shield of California's FEP Responsibility Grid. Contact the appropriate health plan for your service request.

FEP Responsibility Grid

FUNCTION	Blue Cross	Blue Shield
UM – Inpatient		
• Acute Care Inpatient Hospitalizations (Elective and Urgent/Emergent)		X
• Behavioral Health		X
• Transplant Pre-service Reviews		X
• Acute Rehabilitation		X

FUNCTION	Blue Cross	Blue Shield
UM – Outpatient		
• Outpatient Surgery*		X
• Transplant Pre-service Reviews		X

*Prior approval is required for the following surgical services if they are to be performed on an outpatient basis: Surgery for Morbid obesity, surgical correction of congenital anomalies, and Outpatient Surgery to correct accidental injuries to jaws, cheeks, lips, tongue, roof and floor of mouth.

FUNCTION	Blue Cross	Blue Shield
Case Management		
• Specialized Behavioral Health and Oncology CM Programs		X
• Flex Benefits – New programs that are not specified in the Service Plan Benefit (SBP) Booklet and SNF and Long-Term Acute Care Evaluations		X
• Hospice – Home/Respite		X
• Extension of Benefits – In addition to those specified in the SBP		X
• Transplants		X
• Home Health*		X

*Home Health does not require case management unless the patient has used their 25 visit limitation per calendar year. Case Management will review if patient needs additional visits beyond the 25 visits.

FUNCTION	Blue Cross	Blue Shield
Claims Payment – Inpatient and Outpatient		
• Billed on UB-04 form	X	
• Billed on HCFA-CMS-1500 form		X*

*Exception: Ambulatory Surgery Centers can bill on a HCFA-CMS-1500 and submit their claim to Anthem Blue Cross.

FUNCTION	Blue Cross	Blue Shield
Provider Dispute Resolution		
• Facility	X	
• Provider		X
Disease Management	X	
Medical Review Post Claims		
• Inpatient	X	
• Outpatient	X	

*Grievances and appeals, as well as customer service, follow the areas outlined in the grid above.

BlueCard® Program

BlueCard® Program Overview 2

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 at anthem.com/ca > Providers > Enter > Communications > Blue Card® Program Provider Manual.

Health Insurance Marketplace (Exchanges)

Health Insurance Marketplace 2
Important Reminders 2
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Health Insurance Marketplace

The Affordable Care Act (ACA) calls for the development of health plans offered on Health Insurance Marketplaces (commonly referred to as exchanges), as well as health plans not purchased on public exchanges. To support this initiative, Anthem Blue Cross (Anthem) developed and/or designated specific networks to serve these ACA compliant health plans and reflect the needs of our membership. Providers and Facilities can easily identify these ACA compliant plans by the *network name* noted on the Member's ID card.

Critical updates about the products offered on the exchange, Covered California, and the networks supporting these ACA compliant Plans can be found on the Health Insurance Exchange information dedicated web page. Access to this information is located at the following website:

- Go to anthem.com/ca
- Scroll to the bottom of the page, select the hyperlink "Providers"
- Select the hyperlink "Enter"
- Scroll down to *Health Insurance Exchange Information*

In addition to posting information to our website, articles are published in our Provider newsletter, *Network Update*, and sent via our email service, Network eUPDATE, to communicate information about exchanges.

Important Reminders

Providers and Facilities are able to confirm their participation status by using our **"Find a Doctor"** tool. You are able to search by a specific Provider name, or view a list of local in-network Providers and Facilities using search features such as Provider specialty, ZIP code, and plan type.

Accessing the Online Provider Directory:

- Go to anthem.com/ca
- Select **Menu** in the top left corner
- Select **Find a Doctor** to search our online Provider Directory

Providers who have questions on their participation status are encouraged to contact Network Relations by email at CAcontractsupport@anthem.com. **Note:** For Commercial Behavioral Health questions, email BHNetworkRelations@anthem.com.

If you are referring a Member to another Provider, verify that the Provider is participating in the Member's specific network.

It is critical that your patients receive accurate and current data related to Provider availability. As outlined in your Agreement, notify Anthem within 10 business days of all changes listed below.

! **TAX ID changes must be accompanied by a W-9 to be valid.**

- Telephone number for Members to schedule appointments
- Provider location address
- Office hours

- Provider name
- Practice affiliation changes (i.e. Provider joined another group)
- Providers leaving, retiring or joining your practice
- Billing address
- Tax ID number
- Specialties
- Hospital privileges
- Accepting new patients
- Handicapped Accessibility
- Languages offered

Send your change request information timely, preferably within 10 business days, refer to the anthem.com, "Provider Forms" Web page. Select the Provider Forms link.

Health Insurance Exchange Information

To see more information select the Health Insurance Exchange Information link.

Audit

Anthem Audit Policy 2
Audit Appeal Policy 5

Anthem Audit Policy

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Facility or Provider Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Facility or Provider Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Facility or Provider Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Member's Health Benefit Plan and in accordance with this Policy.

Definition:

The following definitions shall apply to this Audit 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).
- Appeal means Anthem's or its designee's review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- 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 a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.
- Audit Report and Notice of Overpayment ("Audit Report") means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for Anthem's or its designee's belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.
- Provider or Facility means an entity with which Anthem has a written Agreement.
- Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines certain Anthem 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. A Recoupment is generally performed against a separate

payment Anthem makes to the Provider or Facility, which is unrelated to the services, which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.

- Supporting Documentation means the written material contained in a Member's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim or position that no overpayment has been made by Anthem.

Procedure:

1. Review of Documents. Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem or its designee within thirty (30) calendar days of Anthem's or its designee's request.
2. Scheduling of Audit. 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.
3. 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.
4. Under-billed and Late-billed Claims. During the scheduling of the 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. These claims may, however, be submitted (or resubmitted for under-billed claims) to Anthem for adjudication.
5. Scheduling Conflicts. Should the Provider or Facility fail to work with Anthem, or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.
6. On-Site and Desk Audits. Anthem or its designee may conduct Audits from its offices or 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 work space 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.

7. Completion of Audit. 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.
8. Provider or Facility Appeals. See Audit Appeal Policy.
9. No Appeal. 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.

Documents Reviewed During an Audit:

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 process. 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 in compliance with the plan of treatment.

Auditors will verify that Provider's or Facility's plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Member's health or medical records. In situations where such documentation is not found in the Member's medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility must review, approve and document all such

policies and procedures as required by The Joint Commission (TJC) or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

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

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Member's health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Member's claim. Other appropriate documentation for Health Services provided to the Member may exist within the Provider's or Facility's ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Member's claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

Audit Appeal Policy

Purpose:

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. The Audit report will contain all the information required by the applicable prompt pay law to provide the Provider or Facility notice of an overpayment and will inform the Provider or Facility of its right to appeal, which appeal will be in compliance with applicable law. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) business days of the date of the Provider's or Facility's receipt of the Audit Report unless applicable law expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. If the Provider or Facility does not timely appeal, retraction will begin at the expiration of the thirty (30) business days unless expressly prohibited by contractual obligations or applicable law.
2. A Provider's or Facility's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's or it designee's sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider's or Facility's agreement to waive the requirements of

any applicable state prompt pay statute and/or provision in an Agreement, which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.

3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue a written acknowledgement to the Provider or Facility of the receipt of the appeal within fifteen (15) calendar days. Anthem or its designee shall formulate an Appeal Response to the Provider or Facility within thirty (30) calendar days. 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 Audit Report. Anthem's or its designee's response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.
4. The Provider or Facility shall have fifteen (15) 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 fifteen (15) 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.
5. Upon receipt of a timely Provider or Facility 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. If appropriate, Anthem's or its designee's final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem's or its designee's final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.
6. If applicable in the state, the Provider or Facility shall have fifteen (15) 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 or commence an arbitration in accordance with the dispute resolution provisions in the Provider's or Facility's Provider contract with Anthem. If no remittance check is received within the fifteen (15) calendar day timeframe or the commencement of an arbitration in accordance with the dispute resolution provisions in the Provider's or Facility's Provider contract with Anthem, then Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.
7. As stated in item 6 above, if Provider or Facility still disagrees with Anthem's or its designee's position after receipt of the final Appeal Response, Provider or Facility may invoke the arbitration provisions in the dispute resolution section of the Provider's or Facility's Provider contract with Anthem.

Fraud, Waste and Abuse Detection

Fraud, Waste and Abuse Detection 2
Pre-Payment Review Program 2

Fraud, Waste and Abuse Detection

Anthem recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for Members, clients, and business partners. Anthem accordingly maintains a program, led by Anthem's Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans. All Claims submissions are subject to review and/or audit for possible fraud, waste and abuse. Prevention and detection of fraud, waste and abuse is in accordance with applicable State and Federal law.

Pre-Payment Review Program

One method Anthem utilizes to detect fraud, waste and abuse is through our pre-payment Claim review program. We employ the prepayment review program for most Facility providers. While acute care hospitals, cancer hospitals, and children's hospitals are not subject to the pre-payment review program, their claims are still subject to review and/or audit for possible fraud, waste and abuse.

With respect to the prepayment review program, through a variety of means, certain Facilities, or certain Claims submitted by Facilities, may come to Anthem's attention for behavior that might be identified as unusual, or for coding or billing or Claims activity, which indicates the Facility is an outlier with respect to /its peers. For example, Anthem uses computer algorithm software tools designed to identify Facilities whose billing practices, including billing or coding practices, indicate conduct that is unusual or outside the norm of the Facility's peers.

Once a Claim or Facility, is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim, coding or billing practice. If the investigation results in a determination that the Facility's actions may involve fraud, waste or abuse, the Facility is notified and given an opportunity to respond.

If, despite the or Facility's response, Anthem continues to believe the Facility's actions involve fraud, waste or abuse, or some other inappropriate activity, the Facility will then be notified or Facility is being placed on pre-payment review. This means that the Facility will be required to submit medical records with each Claim so Anthem can review the services being billed. Failure to submit medical records to Anthem in accordance with this requirement will result in a rejection of the Claim under review. The Facilities will be given the opportunity to request a discussion of its pre-payment review status.

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

The Facility will remain subject to the pre-payment review process until Anthem is satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Facility could face corrective measures, up to and including termination from our Network.

Finally, Facilities are prohibited from billing Members for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other coding or billing issue or for failure to submit medical records as set forth above. Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable facility agreement and state law. Facilities also may appeal such determination in accordance with applicable grievance and appeal procedures.

Glossary

Purpose and Introduction.....2
Glossary of Terms.....2

Purpose and Introduction

We appreciate your participation in the Anthem Blue Cross (Anthem) network. Anthem is committed to working with our Providers and Members to give a high level of satisfaction in delivering quality care. The Anthem Facility Manual is an integral part of this commitment, providing information on key contractual terms, products, eligibility and claims submission, as well as many other topics. The *Definitions*, as indicated in your Agreement with Anthem, shall supersede any terms and definitions offered in this *Glossary.*

As Anthem makes changes to this information, this Manual will serve as a vehicle for communicating such changes.

Glossary of Terms

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

Accreditation. An evaluative process in which a health care organization undergoes an examination of its operating procedures to determine whether the procedures meet designated criteria as defined by the accrediting body, and to ensure that the organization meets a specified level of quality.

Acute Psychiatric Facility. A psychiatric Hospital, designated psychiatric unit of a general acute hospital or psychiatric health facility that is licensed by the state to provide 24-hour acute inpatient care for persons with psychiatric disorders.

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

Administrative Services Only (ASO) Contract. A contract under which a third-party administrator or an insurer agrees to provide administrative services to an employer in exchange for a fixed fee per employee.

Affiliate(s). A corporation or other organization owned or controlled, either directly or through parent or subsidiary corporations by Anthem.

Alternate Birth Center. This network is made up of birth facilities that provide a homelike atmosphere for the mother and infant.

Alternative Birthing Center Services. Services rendered by an alternative birthing center. Alternative birthing center services include related services, such as equipment, surgical and anesthetic supplies; oxygen and drugs; blood and blood processing; laboratory procedures; and diagnostic imaging.

Ambulance. This network is made up of both ground and air ambulance licensed health care providers that transport the Anthem Member to and from the nearest Hospital or skilled nursing Facility (SNF). An appropriately licensed person may provide monitoring (e.g., EKGs and ECGs), cardiac defibrillation cardiopulmonary resuscitation (CPR), and oxygen- and IV-solution administration in connection with the

ambulance service. This network should be used for scheduled services. Members should use the 911 system for emergency services.

Ambulatory Surgical Center. This network is made up of freestanding facilities, other than hospitals and medical or dental offices, whose main function is performing surgical procedures on an outpatient basis.

Anthem Blue Cross. A health care service plan regulated by the California Department of Managed Health Care (DMHC).

Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health). An insurance company regulated by the California Department of Insurance (CDI), and an affiliate of Anthem Blue Cross.

Anthem Blue Cross HMO Participating Provider. A physician, medical group or IPA that has entered in to a *Medical Services Agreement (Anthem Blue Cross HMO participating physician Agreement)* with Anthem Blue Cross to provide medical services to Anthem Blue Cross (HMO) plan Members.

Anthem Blue Cross Managed Care Network. The network of physicians, hospitals, facilities, and other health care professionals that have contracts with Anthem and one or more of its affiliates. Under these contracts, the physicians, hospitals, facilities, and other health care professionals agree to participate in Blue Cross HMO, Blue Cross POS and other programs conducted according to the Benefit Agreement.

Anthem Blue Cross Medical Policy. The Medical Policy & Technology Assessment Committee (MPTAC) is the authorizing body for enterprise medical policy and enterprise clinical Utilization Management (UM) guidelines (hereafter referred to as medical policy), which serve as a basis for coverage decisions. The Office of Medical Policy & Technology Assessment (OMPTA) supports the development of medical policy and clinical UM guidelines for the company. The principal component of the process is the review for development of medical necessity and investigational position statements for certain new medical technologies and/or procedures or for new uses of existing technologies and/or procedures. The technologies include devices, biologics and specialty pharmaceuticals, and behavioral health services.

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

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

ASC X12. An Accredited Standards Committee (ASC) of the American National Standards Institute (ANSI), founded in 1979. Its objective is to develop consensus standards to facilitate Electronic Data Interchange (EDI). A subcommittee of ASC X12 develops EDI standards for insurance.

ASC X12N Standard Format. The standards for electronic data interchange within the health care industry developed by the Accredited Standards Committee (ASC) X12N Insurance Subcommittee of the American National Standards Institute (ANSI).

Assignment. Agreement by the practitioner to accept any reimbursement from a third-party payor as payment in full for the services rendered. When a practitioner accepts assignment, balance billing for charges that were not paid in full is not permitted (except for collection of any deductible, copayment and/or coinsurance that the patient is required to pay).

Authorization. A general term used for clarity in this Facility Manual that refers to the review, approval and/or approval process inherent in the Anthem Medical Management Program. This includes pre-service,

concurrent and post-service reviews. Authorization should be requested prior to services being rendered. Common synonyms include "certification," "prospective" and "review."

Availity Web Portal (Availity). Provides single sign-on, secure, multi-payer access to eligibility and benefits inquiry, claim status inquiry, claim submission, pre-authorizations and more.
! Note: Anthem is targeting January 20, 2017, to retire ProviderAccess® and all functionality will move to the Availity Web Portal (Availity). This change does not affect the anthem.com/ca public website.

If you currently use ProviderAccess tools such as fee schedules, online remits, reports, or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. No further registration is needed if you have already registered with Availity.

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth.

Behavioral Health or Mental Health Facility. Any general acute hospital, psychiatric hospital, psychiatric health facility, chemical dependence recovery hospital, residential treatment center, day treatment facility, or other Anthem care Facility or outpatient setting approved by Anthem.

Behavioral Health Care. The provision of mental health and substance abuse services.

Behavioral Health Provider. Behavioral health care practitioners, including psychiatrists, psychiatric mental health nurse practitioners, psychiatric mental health nurses, psychologists, licensed clinical social workers, marriage and family therapists, and professional clinical counselors. For the provision of Applied BA, we've expanded our panel to include Board Certified Behavior Analysts (BCBAs). The Facility network includes hospital inpatient units, residential treatment centers, partial hospitalization programs, and intensive outpatient services and programs.

Behavioral Health Services. Means those acute care inpatient, residential, rehabilitation, and hospital day treatment outpatient services for the evaluation and treatment of mental disorders and substance abuse conditions, which are covered by a Benefit Agreement providing coverage for mental or nervous disorders, psychiatric disorders, substance abuse, or ABA. Hospital/facility services do not include long-term, non-acute care.

Benefit Agreement. The written agreement entered into between Anthem and a group or individual, pursuant to which Anthem indemnifies health care expenses, provides or administers health care benefits, or otherwise pays or arranges for the payment of benefits for health care services.

Benefit Levels. The extent or degree of service a person is entitled to receive based on his or her contract with a health plan or insurer.

Benefit Package. (1) Services an insurer, government agency, health plan or employer offers under the terms of a contract. (2) The list of Covered Services an insurance plan offers to a group or individual.

Benefit Period. The maximum length of time for which benefits will be paid.

Benefits. The types of care or services an insurance plan will pay for certain types of medical care.

Benefit Substitution. An alternative treatment plan for a Member under case management that may include medical services not covered under the Member's Benefit Agreement. If approved by Anthem, the alternative benefit is offered in lieu of a standard benefit under the Member's Benefit Agreement.

Blue Cross Blue Shield Association (The Association).

BlueCard® Program. BlueCard is a national program that enables Members of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan's service area.

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

Business Partner. An entity involved directly or indirectly with Anthem. For example, software vendors may act as business partners. They provide applications to our Providers to send EDI transactions and may, or may not, directly exchange transactions with Anthem. (See Trading Partner.)

Case Management Program. A program that assesses the Member's medical needs. It includes working with the PMG/IPA and other participating physicians, Hospitals, Facilities, or other health care professionals to explore and coordinate treatment alternatives that may:

1. Increase Member satisfaction
2. Achieve benefit savings
3. Result in better medical outcomes
4. Be more cost-effective

Chemical Dependency Disorders. See *Substance-Related and Addictive Disorders*.

Centers of Medical Excellence (CME) Network – Providers. The health care network that has contracts with Anthem and/or one or more of its affiliates, pursuant to which those Providers have agreed to participate in a transplant program or other designated specialty program that is to be conducted pursuant to the Member's Benefit Agreements. Refer to *Anthem Centers of Medical Excellence – Contract Operations Manual For Transplant Program*.

Centers of Medical Excellence (CME) – Facilities. Anthem has a CME network of transplant Facilities to provide services for specified organ transplants, which may include heart, liver, lung, heart-lung, kidney-pancreas or bone marrow, including autologous bone marrow transplant, peripheral stem cell replacement and similar procedures. These procedures may be covered only at a CME-contracting Facility. Refer to a *Blue Cross PPO (Prudent Buyer Plan) Directory* for a listing of these Facilities.

Anthem has a network of bariatric CMEs to provide medically necessary surgery for treatment of morbid obesity. Bariatric surgeries, such as gastric bypass, are covered only at a CME-contracting Facility.

Certified Nurse Midwife. These health care professionals may perform the following services:

- Family planning
- Prenatal care
- Postnatal care
- Normal delivery
- Routine newborn care

Chiropractic Services. Practitioners who treat neuromusculoskeletal disorders, using manipulation and therapy for spinal and joint adjustments. Anthem contracts with American Specialty Health Network (ASHN) to access their network of participating chiropractors.

Clinical Laboratory. Health care professionals, who collect, test and evaluate specimens (i.e., hematology, immunology, cytology, histology and microbiology).

CMS-1500. The most current health insurance claimClaim form maintained by CMS, recommended by Anthem for use by all health care practitioners.

Coinsurance. An arrangement under which the insured person pays a fixed percentage of the cost of medical care after the deductible has been paid. For example, an insurance plan might pay 80 percent of the allowable charge, with the insured individual responsible for the remaining 20 percent, which is then referred to as the coinsurance amount.

Coinsurance Maximum. The total amount of coinsurance that a Member pays each year before the insurance plan pays 100 percent of allowable charges for Covered Services. Coinsurance amounts differ with each plan.

Continuous Care. Means the hospice nursing care needed on a continuous basis, for a minimum of eight hours a day, during a period crisis, in order to maintain a terminally ill patient at home through palliation or management of the patient's acute medical symptoms.

Coordination of Benefits. A specific method of determining primary responsibility for paying Covered Services under the terms of the applicable Benefit Agreement or insurance policy, and applicable law and regulations, when more than one payor may have liability for payment for services received by a Member.

For the purpose of the *Prudent Buyer Plan Participating Physician Agreement*, coordination of benefits may include various non-duplication arrangements, in addition to traditional coordination of benefits provisions found in group insurance policies.

Copayment or Copay. A type of Member cost sharing that requires a flat amount per unit of service or unit of time. This may be a percentage of the charges but may also be a dollar amount for specified services. The most common percentage copayment is 20 percent. See also, *Coinsurance*.

Copayment Maximum. The limit on the total amount that a Member might have to pay in copayments during any one calendar year, after which the health plan pays 100 percent of allowed charges up to specific benefit maximums.

Course of Treatment. The period of time that a Member receives therapeutic or rehabilitative treatment of a mental disorder or chemical dependency. A course of treatment: 1) begins on the day the Member starts the treatment; 2) runs continuously through the day the Member is discharged from, or voluntarily leaves, the inpatient treatment Facility or outpatient treatment care center; and 3) will be considered completed, provided the treatment has continued for the number of days prescribed by the medical director of an inpatient treatment Facility or outpatient day treatment center, and accepted by Anthem for treatment of the chemical dependency or mental disorder. Note: all Facilities should ensure that an appointment has been scheduled for the Member before the Member is discharged from the Facility. This appointment should happen within seven days of discharge.

Covered Billed Charges. The charges billed by a health care professional at his or her normal rates for services covered by the Benefit Agreement under which a claim is submitted.

Covered Services. Medically necessary services or supplies for which benefits are offered in the Member's Evidence of Coverage (EOC).

CPT Code. Billing code used on CMS-1500 forms for identifying the service(s) rendered to Members. Current CPT codes can be found in the current version of the CPT Manual, which is updated annually.

Credentialing. The review and verification process used to determine the current clinical competence of a Provider and whether the Provider meets the managed care organization's pre-established criteria for participation in the network.

Crossover. The ability to forward claims to the secondary payer after the claim has been processed by the primary payer. Also known as *Coordination of Benefits*.

Custodial Care. Care provided primarily to assist the Member in daily living activities. This includes help in walking, getting in and out of bed, bathing or dressing. It also includes preparing food or special diets, feeding, administering medicine that is usually self-administered, or any other care not requiring the continued attention of trained medical or paramedical personnel.

Customary and Reasonable. This reimbursement formula is determined annually by Anthem, and falls within the common range of fees billed by a majority of providers for a procedure or service in a given geographic region, or is justified based on the complexity or the treatment severity for a specific case.

Deductible. The amount of charges some Members must pay for any covered expense before selected benefits are available under their plan. The Member's deductible is stated in his or her plan.

Detoxification. The medical supervision of withdrawal from alcohol and/or drugs to which a patient was addicted or habituated. These substances do not include tobacco or food substances. Detoxification must require active medical supervision of a brief, protocol-specific substance withdrawal program. Detoxification may occur in a 24-hour Facility or on an outpatient basis, depending upon severity and medical necessity according to the patient's condition and circumstances.

Diagnostic Imaging. Health care professionals who perform radiological procedures, such as X-rays, computerized axial tomography (CAT) scans and magnetic resonance imaging (MRI) scans.

Dialysis Facility. Freestanding renal dialysis facilities provide services for hemodialysis, intermittent peritoneal dialysis, continuous ambulatory peritoneal dialysis, continuous cycling peritoneal dialysis and other miscellaneous dialysis services.

Disease Management. A coordinated system of preventive, diagnostic and therapeutic measures intended to provide cost-effective, quality health care for a patient population who have, or are at risk for, a specific chronic illness or medical condition. Also known as disease state management.

Document Control Number (DCN). A number that is assigned to each claim for reference and payment purposes.

EDI (Electronic Data Interchange). Computer-to-computer transfer of transactions and information. Anthem Providers may use EDI for submitting claims, receiving ERAs, verifying benefits, eligibility, claim status inquiries, and more.

ERA (Electronic Remittance Advice). Allows Providers the option to print or to automatically post payments utilizing their practice management software.

Emergency. A sudden onset of a medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including, without limitation, severe pain); such that the patient may reasonably believe

that the absence of immediate medical attention could result in any of the following:

1. Placing the patient's health in serious jeopardy
2. Serious impairment to bodily functions
3. Other serious medical or psychiatric consequences
4. Serious and/or permanent dysfunction of any bodily organ or part

Extension of Benefits. Extended benefits that may be available to Members who are disabled on the termination date of their Benefit Agreement. Extended benefits are defined in the Member's Benefit Agreement.

Health Maintenance Organization (HMO). A prepaid plan program that provides or arranges for health services to its Members on a prepaid, monthly basis (i.e., capitation).

Home Health Agency. The following services are provided by a Home Health Agency (HHA):

1. Skilled nursing services
2. Post partum nurse
3. Licensed vocational nurse
4. Services of a licensed therapist for physical, occupational, respiratory or speech therapy
5. Services of a medical social worker
6. Services of a home health aide
7. Medically Necessary supplies

Home Infusion Therapy (HIT). Pharmacies that provide pharmaceuticals, supplies and equipment for infusing medication, such as antibiotics, chemotherapy, total parenteral nutrition, pain management and other infusion therapies in the home.

Hospice. A hospice provides palliative care for terminally ill patients.

Hospice Care. An approach to treatment that recognizes the impending death of an individual warrants a change in focus from curative care to palliative care (relief of pain and other uncomfortable symptoms). The goal of hospice care is to help terminally ill individuals continue life with minimal disruption to normal activities, while remaining primarily in the home environment. It includes routine care, continuous care, respite care and inpatient hospice care.

Hospitals. Among Anthem's participating Hospitals are preferred participating Hospitals. These preferred Hospitals are afforded several operational advantages, as described in the Member's Benefit Agreement. To find out if a Hospital is a preferred participating Hospital, call the Customer Service telephone number on the Members's health care identification (HCID) card.

Hospital/Facility Services. Hospital/Facility services means those acute care inpatient, residential, rehabilitation and Hospital day treatment outpatient services that are covered by a Benefit Agreement, providing coverage for mental or nervous disorders, psychiatric disorders or substance abuse. Hospital/Facility services do not include long-term non-acute care.

ICD-10 (International Classification of Diseases, 10th Revision). ICD-10 Procedures and Diagnosis codes.

Independent Practice Association (IPA) and Participating Medical Group (PMG). A legal entity organized under the laws of the state of California that operates under a contract with Anthem to provide and arrange for professional health services to persons who are enrolled in Anthem Blue Cross commercial HMO plans.

Inpatient Hospice Care. Means an inpatient stay necessary to manage acute symptoms, such as uncontrolled pain, severe respiratory distress, hemorrhaging, intractable nausea/vomiting, severe dysfunction, unmanageable behavior, seizures and acute distress, in the actively dying phase. Inpatient hospice care is provided in a Provider-owned or contracted SNF or Hospital and includes, but is not limited to, room and board, nursing care and hospice services.

Intake Representative. Nonclinical Anthem staff who obtain nonclinical and structured clinical information about Members by telephone, FAX, or other electronic means of submission at the time of the request for prior authorization of service or notification of a Member's admission to the Hospital.

Intensive Outpatient Program. A program having organized and structured services that are provided for no less than three hours a day, but usually no more than five hours a day, at least three times per week. The Member should reside in a community setting while receiving intensive outpatient program services and is not in a 24-hour residential treatment setting. With symptom improvement, a gradual decrease in services per week may occur. Components of treatment should include a comprehensive clinical assessment, a psychiatric evaluation upon admission and upon follow up as needed, individual therapy, family therapy, group psychotherapy, psycho-educational groups, skills training, and expressive/activity therapies. For Substance Use Disorder Intensive Outpatient Programs, there should be an evaluation for medication that may improve the Member's ability to remain abstinent or reduce substance use. Treatment should include attendance at community-based recovery programs, drug screens as clinically appropriate, and family involvement in treatment.

Interactive Voice Response (IVR). The Interactive Voice Response unit is an automated computer system that stores and relays the eligibility, benefits and Claims data for a Member.

Intermittent Care. Care provided for periods of time less than two hours in duration and not more than one time per discipline per 24-hour period, unless preauthorized as Medically Necessary by Anthem.

Managed Care Network. The network of health care professionals who enter into contracts with Anthem and/or one or more of its affiliates. Health care practitioners agree to participate in the Anthem programs that are conducted pursuant to Benefit Agreements.

Medical Advisor. A validly licensed physician or other medical expert (e.g., physical therapist, psychologist or licensed clinical social worker) who is employed by, or under contract with, a review organization to carry out utilization reviews.

Medical Provider Network (MPN). A network of Providers, including physicians, created to provide medical treatment for work injuries of employees in California. Self-insured employers or workers' compensation insurers may have an MPN. Under SB 863, an entity providing physician network services can also have an MPN. An MPN must be approved by the California Division of Workers' Compensation (DWC) before it can be used. Unless exempted by law or the employer, all medical care for workers injured on the job whose employer has an approved MPN will be handled and provided through the MPN.

Medical Products and Services. The medical products and services network includes the following:

1. Medical supplies

2. Orthotic appliances
3. Prosthetic devices and services
4. Hearing aids
5. Oxygen equipment and supplies

Medical Services. Those services provided by a physician or other health care professional and covered by a Benefit Agreement.

Medically Necessary. Procedures, supplies, equipment or services that Anthem determines to be:

1. Appropriate for the medical condition symptoms, diagnosis or treatment
2. Provided for the medical condition diagnosis or direct care and treatment
3. Within standards of good medical practice, within the organized medical community; and
4. Not primarily for the convenience of the Member's physician or another Provider; and
5. The most appropriate procedures, supplies, equipment or services that can safely be provided. The most appropriate procedures, supplies, equipment or services must satisfy the following criteria:
   a) there must be valid scientific evidence demonstrating that the expected health benefits from the procedure, supply, equipment, or service are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Member with the particular medical condition being treated more than other alternatives;
   b) generally accepted treatment forms that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
   c) for Hospital stays, acute care as an inpatient is necessary due to the kind of services the Member is receiving or the medical condition's severity and safe and adequate care cannot be received by the Member as an outpatient or in a less intensified medical setting.

Medicare Advantage Plan. A plan offered by a private company that contracts with Medicare to provide Medicare beneficiaries with all their Medicare Part A and Part B benefits. Medicare Advantage plans are HMOs, PPOs, or Private Fee-for-service plans. If a beneficiary is enrolled in a Medicare Advantage plan, Medicare services are covered through the plan, and are not paid for under Original Medicare.

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

Medicare Prescription Drug Plan. A stand-alone drug plan, offered by insurers and other private companies to Medicare beneficiaries that receive their Medicare Part A and/or B benefits through Original Medicare; Medicare Private Fee-for-service plans that don't offer prescription drug coverage; and Medicare cost plans offering Medicare prescription drug coverage.

Member(s). May be used interchangeably with the terms Insured, covered person or individual, enrollee, subscriber, eligible dependent spouse/domestic partner, child, or contract holder, and the meaning of each is synonymous with any such other.

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

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

Anthem pays for the following for Covered Services provided under the Member's Benefit Agreement:

1. The same inpatient services as those provided for any other condition, subject to any limitations applicable to the treatment of mental disorders
2. Any additional inpatient services needed for detoxification during acute withdrawal from alcohol or other drugs

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

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

Medically Necessary marriage, family, or group counseling is covered, subject to the terms of the applicable Benefit Agreement. Each Member attending the session is responsible for his or her own copayment, and each session counts as a visit toward that Member's visit maximum.

Mental Health Parity (MHP). Coverage in a plan for mental health (MH) and/or substance abuse (SA) benefits provided at "parity" or equal coverage with the medical and surgical benefits in the same plan.

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

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

Nonparticipating Hospital. A Hospital that has not entered into a written Agreement with Anthem to provide medical services to Members for prospectively determined rates.

Nonparticipating Provider. A health care professional who has not entered into a written Agreement with Anthem to provide medical services to Members for prospectively determined rates.

Norms. Numerical or statistical measures of observed performance of health care services, derived from aggregated information related to the health care services provided to a statistically significant number of persons, as developed by a review organization.

Occupational Medicine Network. An Anthem health care delivery network that provides health services to injured workers covered by an insured or self-insured Workers' Compensation plan.

Occupational Therapy. Health care Providers specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Open Enrollment. A period during which the employees of an insured employer are allowed to enroll in a health plan.

Other Payors. Anthem has network leasing arrangements with a variety of organizations including, but not limited to, Insurers, Self Insured Employers, and Third Party Administrators that are responsible for payment of benefits, which we call "other payors." Other payors and affiliates use the Anthem network for Members and as such, they are entitled to the same Anthem billing considerations, including discounts and freedom from balance billing.

For a list of *Other Payors (Network Leasing Arrangements)*, refer to *Appendix A* in this Manual.

Out-of-pocket Costs. Costs, such as copayments, coinsurance and deductibles that must be paid by an insured individual.

Out-of-pocket Maximum. Refers to the maximum amount that an insured employee will have to pay for expenses covered under the plan. It is a sum of deductible and coinsurance amounts.

Outpatient Day Treatment. See below: *Partial Hospitalization Program*.

Parity Benefits. Coverage for mental health and/or substance abuse conditions provided on par with medical benefits. Currently mandated by many states and the federal legislation.

Partial Hospitalization Program. Partial hospitalization is a structured, short-term treatment modality that offers treatment in a program at a minimum of six hours per day, five days per week for Members who are able to function in the community at a minimally appropriate level and do not present as an imminent potential for harm to themselves or others. The Member should reside in a community setting while receiving partial Hospital program services and is not in a 24-hour residential treatment setting. With symptom improvement, a gradual decrease in services per week may occur. Components of treatment should include a comprehensive clinical assessment, a psychiatric evaluation upon admission, at least weekly psychiatric follow up visits, individual therapy, family therapy, group psychotherapy, psycho-educational groups, skills training, and expressive/activity therapies. For Substance Use Disorder Partial Hospital Programs, there should be an evaluation for medication that may improve the Member's ability to remain abstinent or reduce substance use. Treatment should include attendance at community-based recovery programs, drug screens as clinically appropriate, and family involvement in treatment.

Participating Hospital. A Hospital that has an Agreement with Anthem to provide Hospital services as a participating Hospital.

Participating Medical Group (PMG) or Individual Practice Association (IPA). A legal entity organized under the laws of the state of California, operating under a contract with Anthem to provide and arrange for professional health services to persons who are enrolled in Anthem Blue Cross Commercial HMO plans.

Participating Physician. A physician who has a written Agreement to provide medical services as a participating health care professional and who is a "licensee," as that term is defined in the *Business and Professions Code, Section 2041*.

Participating Provider. A Hospital, other health care Facility, physician, IPA, PMG or medical group, or other health care professional that has entered into an Agreement with Anthem to provide health care

services at prospectively determined rates. A participating Provider may also be referred to as a "Contracted Provider" or an "In-Network Provider".

Peer Clinical Reviewer. A physician or other health care professional who holds a current California license in the same licensure category as the requesting physician or other health care professional and who is clinically competent to evaluate the specific clinical issues and render a clinical opinion specific to the medical condition, procedure and/or treatment under review.

Per Diem. A fixed payment measure for a day of service.

Physical Therapy. Health care Providers specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Plan. A direct service prepayment plan offered by Anthem, including, but not limited to, Anthem. The terms of coverage are set out in a Benefit Agreement.

Plan Physician. A duly licensed physician who is a shareholder, partner, associate or employee of a PMG or IPA.

Policy(ies). A written Agreement entered into by Anthem Blue Cross Life and Health Insurance Company (Anthem Blue Cross Life and Health) and groups or individuals under which Anthem Blue Cross Life and Health indemnifies health care benefits, including, but not limited to: Anthem Blue Cross Life and Health PPO plans, fee-for-service plans, BC PPO (non-California resident) plans and other Anthem Blue Cross Life and Health plans.

Pre-certification. Review for medical necessity prior to service delivery. Some common synonyms: pre-service, preauthorization and/or pre-auth. See *Authorization*.

Preferred Provider Plan or PPO Plan. A Benefit Agreement in which Members have a financial incentive to use participating health care professionals, including, but not limited to, a *Prudent Buyer Plan Benefit Agreement*.

Preventive Care Center. A preventive care center is a participating Hospital that has an Agreement to provide preventive services to Anthem Members. Qualified health care professionals, under the supervision of a physician, perform the following services:

1. Physical exam and health history
2. Computerized health inventory assessment
3. Blood pressure check
4. Non-fasting finger-stick cholesterol check for Members ages 19 and over
5. Immunizations given as standard medical practice for Members ages seven through 18, except for hepatitis B and varicella zoster; tetanus immunizations for Members ages 19 and over, if none received in previous 10 years; and influenza vaccines, when medically appropriate for Members ages 19 and over
6. Vision and hearing exams for Members ages seven through 18
7. Other medically appropriate diagnostic tests and procedures
8. Health promotion and health education counseling, videos and brochures

Primary Care Physician (PCP). A physician is a licensee, as that term is defined under the Business and Profession Code, Section 2041. A PCP is responsible for requesting authorization for, and coordinating and

controlling the delivery of Covered Services to the Member. PCPs include general and family practitioners, internists, pediatricians and other such specialists as Anthem may approve to be designated PCPs.

ProviderAccess®. Anthem Blue Cross' secure website that enables health care professionals to check Anthem Blue Cross proprietary information online.

! IMPORTANT UPDATE REGARDING PROVIDERACCESS®. Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). This change does not affect the anthem.com/ca public website.

If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. No further registration is needed if you have already registered with Availity. See *Availity*.

Quality Improvement Organization. An organization that provides an immediate review of an appeal initiated by a Medicare enrollee regarding a length of stay at a Facility, as determined by the medical group and/or PCP.

Respite Care. Means short-term inpatient care provided to hospice patients, when necessary, to give the family member or other caregiver relief from care giving responsibilities.

Routine Care. Means the intermittent care provided to hospice patients and their families by nurses, therapists, social workers, chaplains, and other health and psychological/social professionals, in order to provide hospice care where no immediate crisis intervention is needed.

Review Coordinator. A clinically experienced, licensed staff member who reviews and may approve medical care and services as medically appropriate, using approved screening criteria and Anthem medical policy.

Screening Criteria. Those written guidelines adopted by review organization to determine medical necessity, appropriateness and length of stay.

Self-Funded. When a business funds a benefit plan from its own resources rather than purchasing insurance.

Shift Care. Means the provision of nursing services, on an hourly basis, for a longer period of time than an intermittent care visit, for the purpose of providing Medically Necessary care as ordered by the physician.

Skilled Nursing Facility (SNF). A network of freestanding, sub-acute care Facilities that provide services such as:

1. Physical, occupational and speech therapy
2. Nasogastric or gastrostomy tube feedings
3. Nursing services
4. Tracheostomy care
5. Wound care
6. Ventilator care
7. Expanded spectrum IV antibiotics

Specialty Pharmaceuticals (Specialty Medications). Can best be identified by the product

characteristics. If they have some or all of the below characteristics, drugs may be defined as "specialty," thereby requiring distinct distribution processes networks and Utilization Management efforts:

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

Speech Therapy. Health care professionals specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Sub-acute Care Services. Those services specified in the Agreement and covered by a Benefit Agreement.

Substance-Related and Addictive Disorders. These include substance use disorders and substance induced disorders, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM).

Subscribers. Individuals who qualified for, and are covered by, the provisions of a *Prudent Buyer Plan Benefit Agreement*.

Surcharge. An additional fee charged to a Member for a medical service that is not approved by the applicable state regulatory authority, and is neither disclosed nor provided for in the Member's Benefit Agreement. Examples of surcharges include, but are not limited to, concierge or retainer fees, billing fees, Claim handling fees or other administrative service fees not directly related to the provision of health care services to the Member.

Third-party Administrator. A third-party administrator (TPA) is an organization that processes insurance Claims for a separate entity. This can be viewed as "outsourcing" the administration of the Claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance. Often, a TPA handles the Claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA. The employer may also contract with a reinsurer to pay amounts in excess of a certain threshold, in order to share the risk for potential catastrophic Claims.

An insurance company may also use a TPA to manage its Claims processing, Provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent.

Total Eligible Billed Charges. This means the Facility's billed charges for Covered Services, except for those charges that are identified as disallowed charges in the Facility Manual.

Trading Partner. An external entity, such as a customer, clearinghouse or vendor that you do business with. This relationship must be formalized with a Trading Partner Agreement.

Transfer Agreement. A written Agreement between ancillary Facilities and an acute care participating Hospital, within a reasonable distance from the ancillary Facility, to facilitate prompt transfer of patients requiring Hospital care. This Agreement includes the requirement that complete patient information be transmitted with the patient at the time of transfer.

Utilization Review. A function performed by Anthem to review and determine whether medical services provided, or to be provided, are Medically Necessary.

Utilization Review Reference Number. The tracking number given to a physician, Hospital, Facility or other health care professional(s) following creation of a case for review.

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

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

Exhibits

Anthem Centers of Medical Excellence(CME) Transplant NetworkContract Operations Manual

BlueCard® Contact List

Continuity of Care/Transition of Care Request Form

Coordination of Care Form and Letter Templates:

- Coordination of Care Form
- Cover Letter for Behavioral Health Practitioners
- Cover Letter for Medical Practitioners

Facilities Census Feed File Format

Health Care Identification Card Samples:

- Blue Cross HMO
- Blue Cross Point of Service
- Blue Cross PPO
- Covered CA (Health Insurance Exchange)

Independent Review Organization (IRO) Request

Manual Search Tool

Member Authorization Form

Member (Patient) Responsibility Agreement – Waiver Form

Non-member Transplant Form

Patient Consent to Exchange Information

Preventive Health Guidelines

Privacy Notice

Provider Dispute Resolution Request

Remittance Advice Field Descriptions

Timely Filing Acceptable Forms of Proof

Network Leasing Arrangements

Anthem has network leasing arrangements with a variety of organizations, which we call "Other Payors." Other Payors and affiliates use the Anthem Network.

Under the terms of your Agreement, Members of Other Payors and affiliates are treated like Anthem Members. As such, they're entitled to the same Anthem billing considerations, including discounts and freedom from balance billing. You can obtain the Other Payors list on ProviderAccess®, which can be accessed through our Provider website at anthem.com/ca

! IMPORTANT UPDATE REGARDING PROVIDERACCESS®
Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). **This change does not affect the anthem.com/ca public website.**

If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. **No further registration is needed if you have already registered with Availity.**

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth.

Links

- Anthem Blue Cross – Contact Us
  www.anthem.com/ca
- Anthem Blue Cross Provider Network Education
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s0/t0/pw_a131384.htm&rootLevel=3&label=Provider Network Education
- Availity Web Portal (Availity) – single sign-on, multiple payer secure website
  www.availity.com
- Behavioral Health Clinical UM Guidelines
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f3/s5/t0/pw_a115167.htm&rootLevel=2&label=Behavioral%20Health
- Behavioral Health Provider Resources
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s0/t0/pw_e213631.htm&label=Behavioral%20Health%20Provider%20Resources
- BlueCard® Program Provider Manual – Blue Cross Blue Shield Association Provider education tool
  www.anthem.com/ca/provider/f5/s3/t0/pw_e180312.pdf?refer=provider
- BlueCard® website
  www.bcbs.com/already-a-member/coverage-home-and-away.html
- California Department of Managed Health Care (DMHC)
  www.hmohelp.ca.gov
- Centers of Medical Excellence
  http://www.anthem.com/wps/portal/ca/provider?content_path=shared/f2/s0/t0/pw_b144271.htm&label=Centers of Medical Excellence&rootLevel=1&label=Centers of Medical Excellence
- Clinical Practice, Preventive Health, Child and Adult immunizations and Behavioral Health Guidelines
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f2/s2/t0/pw_a118333.htm&rootLevel=1&label=Practice Guidelines
- Federal Employee Program (FEP®)
  www.fepblue.org
- Industry Collaboration Effort (ICE)
  www.iceforhealth.org
- Health Insurance Exchange Information
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f5/s4/t0/pw_e199856.htm&label=Health&Insurance&Exchange&Information&rootLevel=4&
- Medicare Advantage
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f3/s2/t0/pw_a114250.htm&rootLevel=2&label=Medicare%20Eligible
- Medicaid
  https://mediproviders.anthem.com/ca/Pages/home.aspx

- Medical Policy and Clinical UM Guidelines and Pre-Certification Requirements
  http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s1/t1/pw_b147993.htm&label=Medical%20Policy,%20Clinical%20UM%20Guidelines,%20and%20Pre-Certification%20Requirements
- Medical Policy Formation
  www.anthem.com/ca/medicalpolicies/policies/mp_pw_a044135.htm
- Network Updates (Anthem Blue Cross Provider newsletters including Behavioral Health)
  http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f5/s0/t0/pw_b143389.htm&rootLevel=4&label=Network Update
- Office of Patient Advocate (OPA) State of California
  www.opa.ca.gov/Pages/Home.aspx
- Prescription Drug Authorization Form
  http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f1/s0/t0/pw_a119505.htm&label=Pre-Service%20Medical%20Review%20Request%20Forms&rootLevel=0
- Preventive Health Guidelines
  www.anthem.com/ca/provider/f2/s2/t1/pw_a118331.pdf?refer=provider
- Specialty Drug Pre-service Medical Review Program
  www.anthem.com/wps/portal/ca/provider?content_path=provider/f0/s0/t0/pw_a134685.htm&rootLevel=2&label=Anthem%20Blue%20Cross%20Specialty%20Pharmacy%20Program&rootLevel=2&label=Specialty%20Pharmacy%20Program
- W-9 Form (Request for Taxpayer Identification Number and Certification)
  www.irs.gov
- Workers' Compensation
  wcs.anthem.com/WCMCSHomePage.htm

Workers' Compensation

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Medical Provider Network

The Workers' Compensation Reform Legislation, SB899, was enacted to address many of the primary cost drivers and related issues regarding the State of California's Workers' Compensation system. This bill allows our clients who are insurers, self-insured employers, TPAs and "entities providing physician network services" to file an application with the Division of Workers' Compensation to operate a Medical Provider Network (MPN), which is in essence a list of medical Providers for use by injured workers. Clients accessing the Anthem Workers Compensation Network create their MPNs using selected PPO Providers. Clients who choose to implement an MPN as of January 1, 2005 will have control of direction and channeling of an injured worker's medical care for the entire life of the [as opposed to the current 30 days, or 180 days if using a Health Care Organization (HCO)]. As a participating Provider in the Anthem Workers' Compensation PPO network, these injured workers may be directed to you, as they must use MPN Providers for all medical treatment for the entire life of their claim.

! To confirm your MPN status, contact the insurer, employer, or Claims administrator directly prior to performing services.

Maintaining your Anthem Workers' Compensation Network and/or MPN status:

If you choose to terminate your participation in the Workers' Compensation network by terminating your contract or if your demographic information is not current, you will not appear in our online directory and you will be excluded from our clients' MPN. If these items are not maintained, you could be removed from the network and/or Provider directory, which may affect your Anthem Workers' Compensation Network and/or MPN status:

1. It is important to ensure you maintain accurate directory data (addresses, phone numbers and roster, if applicable) as only Providers and Facilities listed in the directory can be part of an MPN.
2. If you are unable to accept new patients, you must refer them to a Participating Provider/Facility within the MPN the injured worker is subject to.
3. If you do not treat Workers' Compensation patients, contact Anthem Workers' Compensation Customer Relations at 1-866-700-2168 toll free.

If you renew your contract, or update your directory data, this will reinstate you into the Anthem Blue Cross (Anthem) Workers' Compensation network. However, this does not automatically reinstate you into the client's MPN. You must contact the client to confirm if you will be reinstated in each MPN you previously participated.

Advantages of Being in an MPN

An MPN is similar to a health plan in which an injured worker must seek treatment from a contracted Provider within the MPN. By participating in an MPN, injured workers will be channeled to you for treatment, which includes referrals to our contracted ancillary networks and Behavioral Health network within Anthem. However, the Anthem EAP network will not receive referrals for injured workers. In the event this occurs, the Anthem EAP practitioner shall refer this client back to the Anthem EAP by calling toll-free 1-800-728-9492, ext. 8732.

MPN Standards

The Division of Workers' Compensation (DWC) has established MPN standards for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. Our contracted Providers/Facilities must adhere to the MPN guidelines below:

- Maintain medical control for the life of the claim.
- Refer within the MPN: Verify that the in-network Provider you wish to refer to is in the MPN. Contact the payor or call us toll-free at 1-866-700-2168.
- Services obtained outside of the MPN may not be paid. Contact the Claims adjuster for authorization for any medical care outside of the MPN.
- After the initial visit, the injured worker can change to any physician of his or her choice within the MPN.
- If the injured worker disputes the diagnosis or treatment plan of the MPN Provider, there is a second- and third-opinion process established by the State of California.
- Maintain medical records, records of accounts and payments, reports, and other documents that were necessary for the delivery of the medical services. These must be maintained for at least five years from the date of delivery of the medical service, and the obligation to maintain such records does not end on termination of the agreement with the Anthem Workers' Compensation Provider Network. All such records, including records pertaining to the cost to the health care practitioner for delivery of the medical care and the payments received by the health care practitioner for such care, will be made available to the MPN, on request, during regular business hours.
- Submit claims to the appropriate Workers' Compensation administrator within 60 days following delivery of health care services.
- Prohibit any surcharges or other billings in violation of the *Labor Code 3751* for Workers' Compensation health care services or balance billing the injured worker.
- The Claims administrator will ensure payment for authorized medical services rendered up to $10,000 while a claim is under investigation, or until such time as a denial of the claim is made by the Claims administrator.

Other Payors (PPO and MPN)

We are providing our Other Payors (Workers' Compensation Insurance Carriers, Self Insured's including Self-Insurer's Security Fund, a group of self-insured employers pursuant to Labor Code section 3700(b) and as defined by Title 8, California Code of Regulations section 5402 a joint powers authority, the state, Third Party Administrators, and Entities Providing Physician Network Services) who are leasing the network access to our Anthem Workers' Compensation Network. As a participating Provider in the Anthem Workers' Compensation PPO network, injured workers may be directed to you by Other Payors for medical treatment.

Online Provider Directory – PPO

The Anthem Workers' Compensation Provider directory is available. Follow the steps below to access our Provider Finder tool.

1. Go to anthemwc.com

2. From the left-hand navigation menu, select the **Providers** tab
3. Choose the link, **Provider Finder** displayed in the middle of the page
4. Select the state option, **California** from the "*Worker's Compensation Provider Finder"* Web page

Assistance is also available by calling toll-free 1-866-700-2168. This online Provider directory will identify Providers/Facilities who treat work-related illness or injuries.

Medical Treatment Utilization Schedule (MTUS)

For all dates of injury, the "presumption of correctness" regarding appropriate medical treatment is the California Medical Treatment Utilization Schedule (MTUS). Information about these guidelines can be obtained by accessing dir.ca.gov/dwc/MTUS/MTUS_RegulationsGuidelines.html

Anthem Workers' Compensation Other Payors

To access a list of Other Payors go online to the Anthem website anthem.com/ca > Providers > ProviderAccess® and login to obtain access.

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If you currently use ProviderAccess tools such as fee schedules, online remits, reports, or for accessing manuals or helpful administrative information, registration in Availity is required to access these tools in the future. Prepare now by registering on Availity with your own unique login and password. **No further registration is needed if you have already registered with Availity.**

Visit availity.com "Help" topics for more information on the tools and access. Start the registration process today to keep your organization's transition smooth.

Grievances

A complaint and grievance process is available for Workers' Compensation. The process description and submission forms will be made available by verbal or written request to the Anthem Workers' Compensation Provider Network.

A complaint regarding an MPN should be submitted in writing directly to the "MPN Contact" for the MPN. The MPN Contact information is required to be posted on the MPN's website, if you cannot locate the information contact Anthem MPN Services at 1-866-700-2168 toll free for assistance. If the MPN does not respond to your complaint within 30 days, the complaint can be filed directly with the DWC at the following address:

DWC MPN Complaints
P.O. Box 71010
Oakland, CA 94612

Network Pricing Questions

For questions regarding payment per your contract rate, contact Anthem Workers' Compensation Customer Relations at 1-855-766-3719 toll free.

Note: If you have a question regarding how the California Official Medical Fee Schedule was applied, contact the customer service number on the EOR. Effective October 15, 2011, the California Division of Workers' Compensation has revised the Medical Bill Submission guidelines for paper bill submission. New regulation includes the use of industry standard forms (CMS form 1450). The full text of the regulations may be accessed at dir.ca.gov/dwc/laws_regulations.htm

Skilled Nursing Facility

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Introduction

This section outlines guidelines and identifies specific coding for billing for services provided by a freestanding Skilled Nursing Facility (SNF) as described in the Provider's *Anthem Blue Cross Comprehensive Participating Provider Agreement, Anthem Blue Cross Ancillary Participating Provider Agreement or the Anthem Blue Cross Facility Agreement*.

Levels of Care

Each Day of SNF Services will be reimbursed at one all-inclusive Rate for the appropriate level of care, as defined below. Services at all levels of care must be reviewed by Anthem. Anthem retains absolute discretion in the determination of all classification levels. Refer to the *Medical Management Program* and *Medicare Advantage* sections of this Manual for additional information.

Basic Services

Per diem rates for all levels include, but are not limited to, the following:

- Semi-private room and board
- Nursing care and supplies
- Case management
- Social services
- Rehabilitative care per level (PT/OT/ST)
- Respiratory therapy & oxygen services
- General catheter care
- Routine labs
- Oral medications
- IV medications
- Administration of medications
- Routine durable medical equipment
- Diabetic monitoring and related supplies
- All standard equipment & supplies
- Meals (including special dietary needs)
- Administration of enteral feedings
- Administration of TPN
- Discharge planning
- Recreational therapy
- Suctioning
- Pain management
- Routine X-rays
- IPPB/pulmoaid
- IV pumps
- Administration of pharmacy supplies
- Routine supplies
- Routine transportation

Levels of Care

Revenue Code	Level of Care 1 Description
0191	• Nursing services up to 3 hours per day Nursing services includes one or more of the following: o Wound Care – Stage 1 o Routine Tracheostomy Care o Peripheral Lines for hydration o Nebulizer Treatments • Rehab (PT/OT/ST) Less than 90 minutes, no less than 3 days/week • Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $100.00 per day when priced at Medicare's allowances*

Revenue Code	Level of Care 2 Description
0192	• Services in Level 1 • Nursing services up to 5 hours per day Nursing services includes one or more of the following: o Wound Care – Stages 2 and 3 o Peripheral and Central Lines (complex and multiple) o Colostomy/ileostomy care o Respiratory Therapy (suctioning, oxygen, tracheostomy care, etc.) • Rehab (PT/OT/ST) 90 minutes or more, no less than 3 days/week • Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $110.00 per day when priced at Medicare's allowances*

Revenue Code	Level of Care 3 Description
0193	• Services in Levels 1 and 2 • Nursing services up to 7 hours per day Nursing services includes one or more of the following: o Wound Care – Stages 4 and 5 o Peritoneal Dialysis • Rehab (PT/OT/ST) 90 minutes or more, no less than 5 days per week • Oral, IV or Subcutaneous Drugs prescribed in conjunction with the diagnosis requiring the admission to a SNF up to $115.00 per day when priced at Medicare's allowances*
Revenue Code	**Level of Care 4 Description**
0194	• Services in Levels 1, 2 and 3 • Nursing services greater than 7 hours per day Nursing services includes one or more of the following: o Ventilator Weaning, which includes: ▪ additional respiratory therapy and treatments ▪ tracheotomy care ▪ mist treatments ▪ related supplies/equipment o Complex Tracheotomy Care which includes ▪ weaning off oxygen ▪ suctioning ▪ cleaning more than twice per shift o Ventilator Dependent

*Anthem shall use the most recent "Drug Pricing File" as published by Medicare as the basis for establishing Medicare's allowance for drugs. If Medicare does not have a fee, Anthem shall use Average Wholesale Price (AWP) minus applicable percentage established by Anthem Prescription Management.

If the Provider believes that the drug will exceed the applicable dollar daily limits set forth in the description of services included in level 1, 2 or 3 reimbursement, then the Provider should provide the CMS pricing, methodology example below, to the Utilization Management (UM) nurse reviewing the case. If Anthem determines that the drug will, in fact, exceed the applicable dollar thresholds, using the pricing described below, Anthem shall pay or administer payment to Provider at the per diem rate of the next highest level of care (not to exceed level 4 per diem) (e.g., level 1 goes to level 2, level 2 goes to level 3, level 3 goes to level 4) for each of those days of care that Member is receiving such drugs or such other period of time that Anthem deems that the per diem rate for the next highest level of care is appropriate.

Other Services

The following services are included in the above reimbursement if performed or offered in-house. If they cannot be performed or offered in-house, they must be provided and billed by a separate Provider who participates in our network(s).

- Diagnostic procedures and/or laboratory testing
- Specialized equipment such as air fluidized or bariatric beds
- Custom splints and orthotics
- Ambulance transportation
- TPN Solution
- Negative Pressure Wound Care Treatments

The following services must be provided and billed by a separate Provider who participates in our network(s).

- Non staff physician visits, i.e., physicians who are not Facility-based operating in the scope of employment
- Custom durable medical equipment such as motorized wheelchairs
- Blood, Blood Plasma and Blood Derivatives
- Hemodialysis

How to Access CMS Drug Pricing:

- Go to CMS.gov
- Choose the Medicare option
- Under *Medicare Fee for Service Part B Drugs* select Part B Drug Average Sales Price
- Choose the link for the current year's Drug Pricing File. Scroll down and select the most current "ASP Pricing File". The files are updated quarterly.
- Scroll down then choose Accept
- Pop-up window displays and select Open. File will download and it can be saved to your hard drive for future use.
- Select the Excel spreadsheet document "*ASP Pricing File.*"

CMS Pricing Example (from the July 2016 ASP Pricing File May 31, 2016)

To price the drug, find the drug by name or HCPCS Code on the current CMS ASP Pricing File (instructions above). A Member who meets level 3 criteria is admitted to a participating SNF. The SNF would like for the level of care to be moved to level 4 based on the daily cost of the Member's drugs.

The Member needs cefepime and micafungin:

- 2 grams of cefepime (J0692) every 8 hours

  Per the CMS File: 500 mg cefepime = $ 2.408

  The patient needs 2 grams (1 gram = 1000 mg) every 8 hours (3 times a day)

2 grams x 3 times a day = 6 grams. 6 grams x 1000 mg = 6000 mg a day.

$2.408 X 6000 mg = 14,268 divided by 500 mg = $28.90 daily cost for cefepime

- 100 mg of micafungin (J2248) per day

  Per the CMS file: 1 mg micafungin = $ 0.943

  100 mg x $ 0.943= $94.30 daily cost for micafungin

$28.90 + $94.30 = $123.40 daily drug costs

Since the drug costs exceed the level 3 threshold of $115.00, care may be authorized at the higher level. This should be requested during admission review or during concurrent review.

Billing Instructions and Requirements

To ensure timely and more accurate claims payment, Anthem has established the following specific billing requirements for SNF Providers. It is highly recommended that Provider bill according to the following requirements to avoid claim rejection and claims processing delays:

1. All SNF services must be billed on a *UB-04 Claim* form. Indicate UM authorization for SNF days.
2. Revenue codes are required for all line items billed. The following revenue codes must be billed to designate the level of care provided:

Level	Revenue Code
1	0191
2	0192
3	0193
4	0194

3. The levels of care listed above are global, all inclusive and there is no allowance for carve outs.

When a SNF provides services for Anthem Blue Cross HMO Members, the Participating Medical Groups (PMGs)/Independent Practice Associations (IPAs) may require that SNF claims be sent to them for review. The PMG/IPA will then forward the claim to Anthem Blue Cross. Check the requirements of the PMG/IPA before submitting a claim. Include any treatment authorization code or intake number, provided by Anthem Blue Cross, or the PMG or IPA, in field 63 of the *UB-04 Claim* form.

For further information, see the *Reimbursement Policies* section of this Manual.

Dialysis Facilities

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Introduction

The Anthem Blue Cross Facility Manual is designed to provide important information about Anthem Blue Cross (Anthem) and its ancillary services Provider operational procedures.

This section outlines general and specific billing guidelines and identifies specific coding for billing of dialysis services as described in the Provider's *Anthem Blue Cross Comprehensive Participating Provider Agreement* (Agreement) to reduce billing errors.

Additional information is available online at anthem.com/ca about the types of services that require claim submission to the Anthem Blue Cross Preferred Provider Organization (PPO) plan, Anthem Blue Cross Health Maintenance Organization (HMO) processing units or the Anthem Blue Cross HMO Participating Medical Group (PMG). A brief overview of electronic billing and contact information for Electronic Data Interchange (EDI) products and services is also included.

Dialysis – Billing Requirements

To ensure timely and more accurate claims payment, Anthem established the following specific billing requirements for dialysis treatment. It is highly recommended that Provider bill according to the following requirements to avoid claim rejection and claims processing delays:

1. Provider will bill according to Anthem billing requirements.
2. Dialysis treatment services must be itemized on a *UB-04 Claim* form by date of service.
3. Drugs, diagnostic services and supplies must be summarized under one date of service, using one line per service. When using billing code J3490 for an unlisted drug, include the National Drug Code (NDC) number, dosage and description right below the line item.
4. Provider must include specific value codes (49, 68) when Epoetin and Procrit is administered during the billing cycle.

   These codes are defined as follows:

   - 49 – The hematocrit reading taken before the last administration of Epoetin during the billing cycle.
   - 68 – The number of units of Epoetin/Procrit administered during the billing cycle (i.e., 1 units of Epoetin at 100.00).
5. Anthem recommends that Provider bill on a monthly basis. However, if the monthly bill exceeds 22 lines, Anthem recommends splitting the claim into separate *UB-04 Claim* forms.
6. For Providers reimbursed on an all-inclusive per treatment basis (Case Rate), the applicable revenue code and CPT code should be provided.
7. When submitting dialysis claim with an attached EOMB for FEP Members, the Medicare value codes are required or the claim will be returned.

Refer to your Agreement for a list of laboratory and drug services included as part of the compensation rate for hemodialysis, intermittent peritoneal dialysis, continuous cycling peritoneal dialysis and hemofiltration.

When administering Epoetin, Procrit and Aranesp injections, Provider should refer to the Anthem Medical Policies and Clinical UM Guidelines for HGB level criteria, which can be found online at anthem.com/ca.

Use your Medicare ID number, not your tax ID number, when calling Anthem about claim or eligibility.

Service Definitions

The following definitions describe specific dialysis treatments, drugs and non-routine services, as well as the specific revenue and CPT codes that should be used to bill for these services.

Case Rate. All-inclusive per treatment rates. Shall include (1) all services (*e.g.* dialysis, or removal of toxins from the blood, nursing, dialysis technician services, but excluding diagnostic tests) provided during a dialysis treatment in accordance with historical medical practice; and (2) Pharmaceuticals and their administration that are required for the treatment of ESRD.

Revenue Code	CPT/HCPCS Code	Service Description
0821, 0824, 0825	90999, 90935, 90937, 90993	Hemodialysis – A procedure for removing waste products or toxic substances from the bloodstream. Each four- to five-hour session is billed and reimbursed as one treatment. This code requires itemization for each date of service.
0831, 0834, 0835	90999, 90945	Intermittent peritoneal dialysis – A waste removal process. Waste is removed directly by flushing a special solution between the abdominal covering and the tissue. This code requires itemization for each date of service. • 10- to 19-hour session; three times per week maximum; each session equals one treatment • 20- to 29-hour session; two times per week maximum; each session equals two treatments • 30-hour session; once per week maximum; each session equals three treatments
0841, 0844, 0845	90945, 90993	Continuous ambulatory peritoneal dialysis – A process that uses the patient's peritoneal membrane as a dialyzer. Spaced, shorter exchanges during the day; longer exchanges at night. This code requires itemization for each date of service.
0851, 0854, 0855	90945, 90947, 90993	Continuous cycling peritoneal dialysis – A process that uses a machine to make longer automatic exchanges during the day and shorter exchanges at night. This code requires itemization for each date of service.

Revenue Code	CPT/HCPCS Code	Service Description
0634, 0635	Q4081 (Epoetin/ Procrit)	**Epoetin/Procrit** – Units must be used in Value Codes Amount in locator fields (39 to 41) and are based on 100 (100.00) units. The appropriate format is "100.00," not "100." This does not require line-item billing. Summarize under one date of service, using one line per service type. Refer to the Anthem Medical Policies and UM Clinical Guidelines at anthem.com/ca for HCT or HGB level criteria.
0636	J0882 (Aranesp)	**Aranesp** – Units must be used based on HCPCS code description. Summarize under one date of service, using one line per service type. Refer to the Anthem Medical Policies and UM Clinical Guidelines at anthem.com/ca for HCT or HGB level criteria.
0381, 0382, 0383, 0390, 0399	P9021, P9038, P9039, P9012, P9022, P9023	**Blood** – Blood, supplies to administer blood and blood processing fees; priced at a percentage of the covered billed charges. This code requires itemization for each date of service.
0889	90999	**Miscellaneous dialysis** – Other – Priced per date of service.
0820	90993	**Dialysis training** – Course not completed.
0820	90989	**Dialysis training** – Completed course. Priced per session; this code requires itemization for each date of service.
(by HCPCS and revenue)		**Non-routine drugs** – Refer to your Agreement.
		For hepatitis "B" vaccine, dialysis patient use 90747 with REV code 0770 priced in addition to hemodialysis service.
[by Current Procedural Terminology (CPT) codes]		**Non-routine imaging** – Refer to your Agreement.
[by Current Procedural Terminology (CPT) codes]		**Non-routine laboratory services** – Refer to your Agreement.

Required Claim Data Elements

To complete a claim, use the information in this section.

Hospital-based Home Infusion Therapy

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Introduction

This section outlines general and specific billing guidelines for all Anthem Blue Cross commercial plans, including, but not limited to, Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross *Health Maintenance Organization (HMO)*, and identifies useful coding in conjunction with the Anthem Blue Cross Facility Manual, and to assist Home Infusion Therapy (HIT) Providers in reducing returned claims.

Hospital-based HIT Providers

Special Billing Requirements

1. Include your tax identification number in the appropriate field.
2. Include your NPI number in the appropriate field.
3. If you are affiliated with a licensed home health agency, the home health agency should bill for nursing services. If you are not affiliated with a home health agency, you may bill for infusion-related nursing.
4. If possible, bill all services/therapies for a given period on one claim form. If two claims are received with the same or overlapping dates of service, the second claim will be considered a duplicate and may be rejected.
5. Services covering a span of days may be billed on a single line. For example, Total Parenteral Nutrition (TPN) per diems may be billed on one line with the unit of occurrence being the number of days the therapy was administered during the time period billed.
6. Bill with the codes provided at the time your Agreement was implemented as updated periodically. These are the only codes payable under your Agreement.
7. For drugs, bill units in accordance with the Health Care Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) code descriptions. The HCPCS or CPT code descriptions of units of occurrence may be different than the vial size dispensed. Generally, HCPCS or CPT codes describe drugs using the generic description; use the HCPCS or CPT codes to identify all manufacturers of a given substance. For example, use “J2550” for promethazine HCL, whether the drug dispensed was a generic or brand-name drug. The code J2550 would be used to describe all manufacturers of promethazine, including Phenergan, Anergan 25, Anergan 50, Phenazine 25, Phenazine 50, Prorex-50, Prothanzine, V-Gan 25 and V-Gan 50.
8. For drugs that do not have a specific HCPCS or CPT code(s) and are billed with unlisted codes (J3490, J7599, J7699 or J9999), provide the National Drug Code, dose, frequency and doctor’s prescription. Do not use the unlisted codes to describe a specific manufacturer and drug when there is an HCPCS or CPT code that describes the generic drug.
9. For all services, the units of occurrence are a required field. Units of occurrence must be based on the HCPCS or CPT description. Revenue codes 0636 for drugs and 0640 for nursing may be used as filler codes for EDI transactions.
10. Bill for no more than 31 days on a claim form.
11. Services allowed under the Agreement include those that are provided in the Member’s home.
12. Use modifier SV to identify pharmaceuticals delivered to the Member’s home but not utilized.

Service Definition

Professional Services

Infusion nursing services will be allowed at the per-visit rate specified in Exhibit A of the Agreement for visits up to two hours. Additional hours will be allowed at the per-hour rate. In addition, percutaneous intravenous catheter central-line (PICC) professional services, and midline central-line insertions professional services, affiliated with a home health agency, should be billed in accordance with the billing instructions in the Blue Cross Facility Manual, with the changes in billing codes for home health agency.

Drugs

Except for those included in the per-diem reimbursement rates listed in Exhibit A of the Agreement, compensation for drugs is covered in the Anthem Blue Cross (Anthem) Fee Schedule. Certain restrictions will apply to the codes and items that are payable under the Agreement. The fee schedule is updated quarterly consistent with CMS, and Anthem will implement systematically within ninety (90) days of publication.

The following are prescription drug benefits and are specifically excluded from the Agreement:

- Oral drugs
- Topical
- Insulin
- Syringes prescribed and dispensed for use with insulin
- Glucometers, lancets and test strips for use in monitoring diabetes

These are generally covered under the Member's prescription drug program.

Medical Specialty Drugs

Certain specialty pharmacy medications must be obtained through a participating medical specialty pharmacy (MSP) Provider. Refer to your Agreement for specific exclusions.

Equipment, Supplies and Other Services

HIT per diems are defined by the HCPCS definitions and, in accordance with the National Home Infusion Association National Coding Standard for Home Infusion Claims under the Health Insurance Portability and Accountability Act (HIPAA), include the following:

- Pharmacy professional and cognitive services
- Dispensing
- Overhead and operational expenses
- HIT-related equipment and supplies
- Comprehensive 24 hours per day, seven days per week delivery and pick-up services
- Clinical coordination

- Inventories and accounts receivable
- Costs associated with insurance requirements
- Costs associated with accreditation requirements
- Costs associated with administrative requirements

Products and services not included in the therapy per diems are:

- Medications (drugs) and enteral formulae
- Field-based nursing services (high-tech, IV nursing visits)
- Percutaneous intravenous catheter central-line (PICC) and midline insertion procedures and associated supplies
- Surgically implanted central vascular access devices
- Blood products

Drug therapy per diems will be allowed only for those days when one or more covered drug therapies are actually administered to the Member. If applicable, a per diem for catheter care maintenance will be allowed for days between drug therapies when a catheter is being maintained but no drug therapy is being administered.

Required Claim Data Elements

To complete a claim, use the information found within this section.

Home Health Agency

Introduction.....2
Services.....2
Billing Requirements.....2

Introduction

This section outlines general and specific billing guidelines and identifies useful coding for use in conjunction with the Anthem Blue Cross Facility Manual to help the home health agency Provider reduce the number of returned claims.

Helpful information is available about the types of services that require claim submission to the *Anthem Blue Cross Preferred Provider Organization* (PPO) plan, *Anthem Blue Cross Health Maintenance Organization* (HMO) processing units or the *Anthem Blue Cross HMO Participating Medical Group* (PMG).

Services

Your Agreement includes the following services:

- Skilled nursing (non-infusion related)
- Infusion therapy skilled nursing
- PICC and midline central-line insertion
- Postpartum nurse
- Licensed vocational nurse
- Home health aide
- Physical therapy
- Occupational therapy
- Respiratory therapy
- Speech therapy
- Other professional therapy
- Medical social services
- Non-infusion related equipment and supplies

Home health agencies should not bill for any infusion equipment, supplies or drugs; they are not covered under the *Anthem Blue Cross Comprehensive Participating Provider Agreement* (Agreement). These services should be billed by a participating home infusion Provider or participating specialty pharmacy. Items billed that are not on the Anthem Blue Cross (Anthem) Fee Schedule will not be payable and are not billable to the Member.

Billing Requirements

1. Bill on a *UB-04 Claim* form.
2. Include your six-digit Medicare certification number or your Anthem-assigned number in box 51 of the *UB-04 Claim* form. This number identifies you in our system as a network Provider and must appear on the *UB-04 Claim* form. If you are not a Medicare-certified home health agency or hospice, then Anthem will assign a six-digit Anthem ID number to be used for billing and identification purposes only.
3. Bill with current and appropriate 'Bill Type' according to the National Uniform Billing Committee in the Official *UB-04 Data Specification Manual* for Home Health Agencies.

4. Bill with the current Healthcare Common Procedure Coding System (HCPCS), Current Procedural Terminology (CPT) and Revenue Codes, which are updated periodically as new codes are issued.
5. Bill all infusion-related nursing with infusion nursing codes. If correctly identified, infusion-related nursing visits will not deplete a Member's home health visit benefits.
6. For professional services, each visit to the Member's home must be shown on a separate line.
7. The unit of occurrence is a required field for all services. Units of occurrence must be based on the HCPCS or CPT description.
8. Bill at your standard retail rates, not at contracted rates.
9. Include any treatment authorization code or intake number, provided by Anthem, or the PMG or Independent Practice Association (IPA), in field 63 of the *UB-04 Claim* form.
10. When billing electronically, use a "G" code, corresponding to the service, as a filler in column 44. The units of occurrence should not be based on the "G" code description. Use "G" codes G0151-G0156.

For more information, see the *Reimbursement* section of your Agreement.

! Note: For home health agencies with Agreements effective or amended before April 1, 2003, use only hourly codes for skilled nursing non-infusion and home health aide. Do not use per visit codes.

Hospice

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Service Definition 2
Special Billing Requirements 2

Introduction

This section provides a service definition and specific billing requirements for hospice services.

Service Definition

Hospice rates include all procedures, equipment, supplies, medications and services related to a Member's terminal illness. Hospice services will be allowed on either a per-date-of-service or per-hour basis. Medicare guidelines will be applied. All hospice services are subject to coverage under the Member's Benefit Agreement.

Hospice services are as follows:

1. Routine home care (per-date-of-service) – revenue code 0651
2. Continuous home care (minimum of eight hours) – revenue code 0652
3. Inpatient respite care (per-date-of-service) – revenue code 0655
4. General inpatient care (non-respite care; per-date-of-service) – revenue code 0656

Physician services are not reimbursable under the *Anthem Blue Cross Comprehensive Participating Provider Agreement* (Agreement). These should be billed by the physician under his or her contract with Anthem Blue Cross (Anthem).

Special Billing Requirements

Inpatient Hospice

1. Bill on a *UB-04 Claim* form.
2. Include your six-digit Medicare certification number or your Anthem-assigned number in box 51 of the *UB-04 Claim* form. This number identifies you in our system as a network Provider and must appear on the *UB-04 Claim* form. If you are not a Medicare-certified hospice, then Anthem will assign a six-digit Anthem ID number to be used for billing and identification purposes only.
3. Bill with current and appropriate 'Bill Type' according to the National Uniform Billing Committee in the Official *UB-04 Data Specification Manual* for Hospice.
4. Bill with the revenue codes listed above. These are the only codes payable under your Agreement.
5. The unit of occurrence is a required field for all services. **!** Note: Each date of service must be separately reported.
6. Bill at your standard retail rates, not at contracted rates.
7. Include any treatment authorization code or intake number, provided by Anthem, or the *Participating Medical Group* (PMG) or *Independent Practice Association* (IPA), in field 63 of the *UB-04 Claim* form.
8. Inpatient hospice services must be billed on a separate *UB-04 Claim* form from home hospice.

Ambulatory Surgical Center

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Ambulatory Surgical Center (ASC) Guidelines 2
ASC Payment Structure 3
ASC Billing Requirements 3
ASC Implant Billing 5
Diagnostic/Pathology Studies and Other Tests 6
EDI, EFT and ERA 6

Introduction

This section provides information specifically for the Ambulatory Surgical Center (ASC) by outlining general and specific billing guidelines and identifying useful coding to help facilitate claims submission and processing.

Helpful information is available about the types of services that require claim submission to Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross Health Maintenance Organization (HMO) processing units, the Anthem Blue Cross HMO Participating Medical Group (PMG) network, or Anthem Blue Cross Federal Employee Program (FEP) processing area.

Definition of Ambulatory Surgery Center (ASC)

Ambulatory Surgery Center (ASC) means a free-standing facility with an organized staff of physicians, which has permanent facilities and equipment for the primary purpose of performing surgical procedures on an outpatient facility basis and provides treatment by, or under the supervision of, physicians and nursing services whenever the patient is in the facility. The ASC must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services. Staff physicians are required to join Anthem Blue Cross Prudent Buyer (PPO) network before an ASC participation request will be considered. If an ASC is physician owned, the state license is not required.

ASCs must be accredited by one of the following organizations:

- Medicare Certification with passing survey
- TJC – The Joint Commission (formerly JCAHO)
- AAPSF – Accreditation Association for Podiatric Surgical Facilities
- AAAHC – Accreditation Association for Ambulatory Health Care
- AAAASF – American Association for Accreditation of Ambulatory Surgery Facilities
- IMQ – Institute for Medical Quality, with a safety certification

Ambulatory Surgical Center (ASC) Guidelines

The following are general guidelines for billing Anthem Blue Cross:

1. **Billing requirements per contract.** Anthem Blue Cross billing requirements apply to all Anthem Blue Cross Member claims, **except** services administered through Medicaid and other state-sponsored programs.
2. **Claims.** When not submitted in accordance with requirements, claims cannot be readily processed and will be returned to the ASC for correct billing.
3. **Revenue codes.** For claims submitted on a *UB-04 Claim* form, use the appropriate revenue codes for surgery and implants (see ASC Billing Requirements #4).
4. **Type of bill code.** All claims must have the appropriate type of bill code: 831, 835, 837 or 838. The three-digit type of bill code provides the appropriate type of Facility, billing classification and frequency information.

ASC Payment Structure

Payment for an ASC visit will be the lesser of Eligible Billed Charges or 100 percent of the Primary Procedure negotiated rates. The Primary Procedure is defined as the procedure with the highest compensation rate. Additional procedures will be subject to multiple surgical reductions and will be reimbursed at the lesser of Eligible Billed Charges, or 50 percent of the negotiated compensation rate.

Codes that are not specified on the Anthem ASC Pricing Group list are not payable in an ASC setting. Anthem Blue Cross will review and determine the appropriate ASC group, if any, for unlisted surgical procedures that are not specified in the ASC Pricing Groups. Anthem Blue Cross reserves the right to update the Anthem ASC Pricing Groups based on the introduction of new codes, deletion of codes or changes in technology

Pricing for all ASC services is based on a global rate. A global rate is defined as the total charge for a specific set of services, including, but not limited to:

- Facility use global
- Equipment (including rental equipment, monitors, lasers)
- Supplies
- Pharmaceuticals
- Blood
- Laboratory/pathology
- Radiology
- Imaging services
- All other services incidental to the ASC visit

ASC Billing Requirements

1. The following information outlines specific billing requirements for all ASC services. It is required that Facilities bill according to these requirements to avoid having their claims sent back. Bill on a *UB-04 Claim* form. Forms can be obtained from any medical forms/publications publisher. Valid types of bill codes on ASC claims include:

2. 831 – Admit through discharge
    - 835 – Late charge(s) only
    - 837 – Adjustment of prior claim
    - 838 – Void/cancel prior claim

3. Be sure to complete all of the necessary information on the UB-04 Claim form, including:
    a. Subscriber/Member information
    b. Indicate only revenue code 490 (Ambulatory Surgical Care – General Classification) in locator 42 when billing surgical procedures
    c. Referring physician information in locator 76, as appropriate

d. Description of services in locator 43
e. Provide the appropriate Current Procedural Terminology (CPT-4) code in locator 44 for each procedure performed; refer to the latest list of approved procedure codes furnished by Anthem Blue Cross

4. Billing for implants
   a. On a separate line, use the appropriate Revenue Code 274, 276 or 278 in locator 42 for each implant type (refer to your Exhibit for more specific Revenue and CPT codes)
   b. Description of item in locator 43
   c. Provide the appropriate HCPC code in locator 44 for each implant/item provided

5. Bilateral and Multiple procedures

   Valid modifiers include:
   - 50 – Bilateral procedure * do not use LT/RT modifiers to represent bilateral procedures
   - 51 – Multiple procedures

MSR Fee Schedule Example: (both procedures are in the same Group)

CPT	Contracted Rate	Allowable Percentage	Anthem Allowed
55555	$500	100%	$500
22222	$500	50%	$250
		TOTAL ALLOWED	$750

MSR Fee Schedule Example: (procedures are in different Groups – the higher allowed is primary)

CPT	Contracted Rate	Allowable Percentage	Anthem Allowed
44444	$800	100%	$800
55555	$500	50%	$250
		TOTAL ALLOWED	$1,050

Bilateral procedures will be reimbursed at the lesser of Eligible Billed Charges or 150 percent of the Primary Procedure negotiated rate and will be subject to multiple surgical reduction (MSR) edits when the same Provider performs additional bilateral procedure(s). Additional sets of bilateral procedures will be reimbursed at the lesser of Eligible Billed Charges or 75 percent of the negotiated rate.

Bilateral Fee Schedule Example: with – 50 * not to be billed with LT/RT on separate lines

CPT	Contracted Rate	Allowable Percentage	Anthem Allowed
55555-50	$1,200	150%	$1,800
		TOTAL ALLOWED	$1,800

Multiple Bilateral Fee Schedule Example: with – 50 * not to be billed with LT/RT on separate lines

CPT	Contracted Rate	Allowable Percentage	Anthem Allowed
55555-50	$800	150%	$1,200
55555-50	$800	75%	$600
		TOTAL ALLOWED	$1,800

Bilateral and Single Code Fee Schedule Example: the higher bilateral allowed is the primary procedure, single line is secondary

CPT	Contracted Rate	Allowable Percentage	Anthem Allowed
55555-50	$1,200	150%	$1,800
44444	$1,500	50%	$750
		TOTAL ALLOWED	$2,550

ASC Implant Billing

Implantable Medical Device or Implants means objects or materials which are implanted such as a piece of tissue, a medical device, a tube, a graft, or an insert, with the intention of being placed into a surgically or naturally formed cavity of the human body to continuously assist, restore or replace the function of an organ system or structure of the human body throughout its useful life.

Implants include, but are not limited to: stents, artificial joints, shunts, pins, plates, screws, anchors and radioactive seeds, in addition to human tissue, non-soluble or solid materials used to augment tissues or to fill in areas traumatically or surgically removed. In addition to meeting the above criteria, Implants must also remain in the Covered Individual's body upon discharge from the outpatient procedure. Staples, sutures, clips, as well as temporary drains, tubes, and similar temporary medical devices shall not be considered Implants

Implants must be billed on a *UB-04 Claim* in conjunction with covered CPT codes published on the Anthem ASC Pricing Groups. Implants should be billed with accurate HCPC when available. L8699 should only be used when no other HCPC applies. Unless otherwise negotiated in a separate agreement, implants are to be billed by the ASC where services were rendered. Implants are not to be billed directly by a third party. Invoices received from third party vendors are not separately payable and are the responsibility of the Facility. Payment for implants will be the lesser of Eligible Billed Charges up to the total negotiated implant rate per implant type, not per line.

Implant Fee Schedule Example

CPT/REV	HCPC	Billed	Contracted Rate	Max Allowable	Anthem Allowed
55555	N/A	$1,800	$800	$800	$800
REV278	L8690	$1,100	100% up to $1500	$1,100	$1,100
REV278	L8699	$1,500	100% up to $1500	$400	$400*

** Maximum contracted rate for REV278 was 1500 for the entire claim, not per line*

Diagnostic/Pathology Studies and Other Tests

Participating Anthem Blue Cross HMO medical groups, Independent Practice Associations (IPAs) and PPO Providers **should not** refer Members to participating ASCs for diagnostic studies and tests. If the ASC bills Anthem Blue Cross for diagnostic studies and tests, the claim will be denied because the ASC contract does not reimburse for diagnostic tests or studies, only current "procedural terminology procedures" grouped for an ASC. The ASC contract is strictly for surgical services, not tests.

When an HMO Member is referred to a participating ASC for diagnostic studies and tests, it is the responsibility of the PMG/IPA to reimburse the ASC that performed these studies and/or tests. When a PPO Member is referred to an ASC for diagnostic studies and tests, Anthem Blue Cross will deny the claim, and it will be a Provider write-off, because the ASC contract is strictly for surgical services.

EDI, EFT and ERA

Please refer to the *General Billing Requirements* subsection of *Claims Submission* section of this Manual for more information about Electronic Data Interchange (EDI), Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA). You may also contact them directly at the following:

E-Solutions Contact Information	
Hours available:	8 a.m. to 4:30 p.m. PST
Website/Live Chat:	anthem.com/edi – Select State CA > Select the button at the top of the screen for Live Help
Toll-free Telephone Number:	1-800-470-9630
Email address:	e-solutions.support@anthem.com

Behavioral Health and Substance Abuse

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Introduction

This section provides information specifically for the Behavioral Health and Substance Abuse Network including, but not limited to, the admission process, discharge planning, medical necessity criteria, general requirements and specific billing guidelines.

Admissions Process

Elective Admissions

All elective admissions require prospective review. The process begins with a telephone call from the subscriber or treating physician, the physician's office staff or a Facility representative prior to the planned admission. The Anthem Blue Cross (Anthem) Interactive Voice Response (IVR) unit prompts the caller to enter the subscriber's ID number. The IVR routes the call to the appropriate Utilization Management (UM) department.

The intake representative confirms eligibility, obtains demographic information, establishes the case online and forwards the case to the clinical reviewer. The clinical reviewer screens the case using approved criteria and/or Anthem medical policy. When the admission meets criteria, the admission is certified and an initial length of stay is assigned. The requesting physician, Hospital, Facility or other health care professional is notified by telephone or fax, of the approved initial length of stay and the UM reference number. The UM reference number is used for tracking purposes only and does not constitute a promise to pay. It is the Members and Providers responsibility to confirm eligibility and benefits prior to seeking treatment. In addition, all or part of an admission may not be eligible for payment, even if Anthem certifies that the stay is medically necessary.

Non-elective or Non-pre-certified

If an elective admission was not pre-certified or the admission was unplanned, the Facility must notify Anthem of the admission on the first business day following admission.

Once notified of an admission, including urgent or emergency admissions, the clinical reviewer assesses the severity of the illness, and certifies the level of care when criteria are met. Continued Stay Review (CSR) continues until care is determined to no longer be medically necessary. CSR includes discharge planning from the first day of admission and may occur by telephone or fax.

Medical Necessity Criteria

Medical necessity criteria are Clinical Guidelines used by utilization review and care management staff, such as a licensed registered nurse or licensed independent behavioral health practitioner (e.g., marriage and family therapist, licensed clinical social worker, registered nurse, or a person who holds a doctorate in a behavioral health field). When the clinical information given meets the criteria, authorization may be given by the utilization review care manager. When cases do not meet these criteria, cases must be sent to a psychiatrist reviewer/peer clinical reviewer for an assessment of the case.

These Clinical Guidelines are used in reviewing applications and when reviewing new programs at existing participating Facilities in order to assure that the program or Facility provides the type and intensity of services required by Anthem. Should a Facility and/or specific service or program consistently not meet the medical necessity criteria, the Facility and/or program will be reviewed for possible termination or removal from the *Anthem Blue Cross Mental Health Participating Hospital/Facility Agreement* (Agreement).

The Clinical Guidelines are updated yearly or as needed and the most current guidelines can be accessed from the Behavioral Health Provider Resources Web page.

For answers to any questions on these criteria, contact Managed Care Services and UM. Department contact information is listed in the *Directory of Services*. Select this link, Behavioral Health Clinical Guidelines to access the guidelines from our website.

Discharge Planning

Discharge planning is initiated on the day of admission and includes appropriate continuing care plans with the preferred outpatient visit within one week of discharge.

Follow-up Referrals within 7 Days after Discharge

Anthem is committed to a quality improvement program in conjunction with Anthem contracted Facilities and professional Providers that encourages a follow-up appointment, with a lower level of care, within seven days after discharge from an acute psychiatric program. The goal of the program is to increase quality of care and decrease the likelihood of relapse or re-hospitalization.

Medical Management Services

The Anthem Medical Management Specialists (MMS) Team and Anthem Utilization Management associates work with Anthem Members and Anthem Facility and professional Providers to coordinate treatment. The goal is to increase the quality of patient care. Quality Management and other discharge planning staff may expect telephone inquiries from the Anthem MMS Team and/or an Anthem UM associate. Anthem contracted Facilities shall cooperate with requests from Anthem MMS and from UM associates and provide the information necessary to ensure the highest quality of care possible.

Health Plan Employer Data and Information Set (HEDIS®) is a set of standardized measures that specifies how organizations collect, audit and report performance information created by the National Committee for Quality Assurance (NCQA). HEDIS measures the quality of care and services provided by health plans. HEDIS consists of a set of performance measures that compares how well health plans perform in the following key areas:

- Quality of care
- Access to care
- Member satisfaction with the health plan and doctors. NCQA requires health plans to collect this information in the same manner so that results can be compared to one another fairly.

Anthem MMS will contact Facilities to obtain Member information for HEDIS purposes including:

Discharge Planning

- Patient Admit Date – The date the patient was admitted into the inpatient Facility
- Planned referral to Next Level of Care – Including Residential Treatment Center, Partial Hospitalization Program, Intensive Outpatient Program or Outpatient Mental Health Professional
- Confirmation of Referral Appointment – If available, confirmation of the follow-up appointment to the next level of care has been kept by the Member. Appointment confirmation will help ensure completion of the discharge planning process

Member Phone Number

- Occasionally, the Member's telephone number on file with Anthem may have become outdated. The Member must provide the Facility with an updated telephone number.
- Contracted Facilities shall make best efforts to return telephone calls to a MMS within one (1) business day. In addition, the contracted Facility shall provide the information requested.

HIPAA Regulations and HEDIS

As a reminder, HIPAA regulations permit disclosure of protected health information (PHI) for treatment, payment and health care operations. In addition, under HIPAA regulations, health care Providers are permitted to disclose protected health information to a health plan for HEDIS purposes, provided the timeframe in which information is needed overlaps with the period the patient was enrolled in the health plan.

Below are some examples of PHI requested for treatment, payment and health care operations:

- Discharge planning information
- Services rendered
- Information on submitted claims

Delegated Utilization Management

"Anthem Blue Cross Behavioral Health also delegates Behavioral Health Utilization Management to select California commercial membership to an IPA in California. This IPA performs Utilization Management activities at specific Facilities in CA. It is responsible for authorizing, providing or arranging for covered behavioral health services and quality care to Members. Anthem Blue Cross' Behavioral Health Department and its Regulatory & Accrediting Oversight department monitor the IPA to ensure that high-quality medical care is delivered to its Members."

Behavioral Health Facility General Responsibilities

- Cooperate with Anthem's Quality Improvement Program and Utilization Management Program.
- All clinical services provided to Members must be by independently licensed behavioral health practitioners. Substance abuse services may be provided by certified substance abuse counselors.

- Respond to requests made by MMS and UM.
- Allow access to medical records to the extent allowed by federal and state law.
- Maintain the confidentiality of Member information and records, and comply with Anthem's *Notice of Privacy Practices* and associated HIPAA standards.
- Ensure the hours of operation are sufficient to prevent delays detrimental to the health of Members and that any restrictions in hours during the usual hours of operation will not cause problems with access and availability for Members.
- Refer Members only to other participating Anthem Providers, such as professional, ancillary or hospital Providers.
- Render treatment and be reimbursed for those services, which are in accordance with the applicable *Agreement* and/or behavioral health benefit plan. In the event Anthem fails to pay a participating Facility for the provision of Medical Services, the Member shall not be liable to the participating Facility for sums owed by Anthem.
- Except for copayments, coinsurance and/or deductible amounts required by the applicable Benefit Agreement, the participating Facility shall not invoice or balance bill a Member for any difference between the Provider's billed charges and the reimbursement paid by Anthem.
- Only in certain circumstances may a participating Facility charge a Member. Facilities are prohibited from charging Members for any service that is deemed not medically necessary or is not a covered service, unless the Member specifically requests such service and agrees in writing to be financially responsible for the service. A denial for medical necessity must take place before the Member is approached for financial responsibility.

  Signature on a general admission statement/agreement does not qualify for this purpose. Facilities must use the *Member (Patient) Responsibility Agreement – Waiver Form* located in the *Exhibits* section of this Manual. If this form is not used, Members are not responsible for services deemed as not medically necessary – leaving the financial responsibility to you, the Provider, to write off the cost for the care not paid by Anthem.

Continuity of Care

California legislation requires health plans to provide, on request, continuity of care to Members in a current course of treatment with a Provider at the time the Provider's contract with the plan terminates, or to certain newly covered enrollees who, at the time their coverage became effective, were receiving services from a non-participating Provider. This California legislation expands the rights for Members to have a smooth transition to a new Provider and to complete a course of treatment with the same Provider, or to maintain the same Provider under certain circumstances.

Continuity of care will be provided for requesting Members:

- In an active course of treatment for an acute medical or behavioral health condition;
- In an active course of treatment for a serious chronic condition;
- Who are pregnant, regardless of trimester, through the postpartum period;
- With a terminal illness;
- Who are newborn children 36 months or younger; or

- Undergoing a surgery or other procedure(s) that has been authorized by the plan or its delegated Provider, and is scheduled to occur within 180 days of the contract's termination (or within 180 days of the effective date of coverage for a newly covered enrollee).

Coordination of Care

Anthem encourages communication between all physicians and health care professionals who are involved in providing care to Anthem Members. A dialogue between the health care professional, primary care physician (PCP) and/or psychiatrist is essential to complete a comprehensive clinical assessment and to effectively coordinate care. Discuss the importance of this communication with each Member and make every reasonable attempt to elicit his or her permission to coordinate care.

HIPAA allows the exchange of information between covered entities for the purposes of treatment, payment and health care operations. You may ask the Member to sign the *Patient Consent to Exchange Information* form prior to any communication; a copy may be retained in the Member's file. The form is not required to be completed by the Member. If the Member declines, his or her decision should be documented in the Member's medical record.

Although this form is offered by Anthem and not required, you may decide to use it for all patients. A copy of the *Patient Consent to Exchange Information* form is in the *Exhibits* section of this Manual.

Note: This does not include psychotherapy notes.

Disclosure of Psychotherapy Notes

HIPAA allows the exchange of information between covered entities for the purposes of treatment, payment and health care operations. This exchange refers to general medical records and not psychotherapy notes. Psychotherapy notes are notes recorded (in any medium) by a health care Provider who is a mental health professional documenting or analyzing the contents of a conversation during a private counseling session or a group, joint, or family counseling session and that are separated from the rest of the individual's medical record. ! Psychotherapy notes do not include medication or prescription information or monitoring, counseling session start and stop times, modalities and frequencies of treatment furnished, results of clinical tests, or any summary of diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date.

A physician or health care professional is prohibited from releasing a patient's psychotherapy notes unless certain conditions are met. A requesting agent must submit a written request to the health care professional and a notice to the patient.

The written request will include:

1. A description of the specific information requested and a description of its intended use.
2. The length of time the information will be retained.
3. A statement indicating the information will not be used for a purpose other than its intended use.
4. A statement indicating the information will not be retained beyond the specified time and that the information will be destroyed or returned to the health care professional.

Requests for Disclosure of Medical Information

HIPAA also requires that a person or entity seeking to obtain medical information must obtain authorization from the patient. It further prohibits plan contractors, corporations, or their subsidiaries and affiliates from intentionally sharing, selling or using any medical information for any purpose not necessary to provide health care services to the Member.

Medical Record Keeping and Documentation Standards

Participating Facilities agree in their Provider contracts to prepare and maintain all appropriate records on services rendered to Members who are Members of any Anthem product. See *Product Summary* section for more information.

Such records must be established and maintained in accordance with professional record-keeping procedures and as required by state and federal regulatory agencies. These records shall accurately reflect significant elements of the patient's assessment, treatment, progress and discharge. The Care Management and Utilization Review staff or the third-party payor may request copies of these records as part of its care management/utilization review or quality assurance functions.

Anthem Medical Record Keeping and Documentation Standards:

Confidentiality

- All personnel having access to Member records will sign a confidentiality statement.
- Medical information may not be disclosed without the consent of the Member. Members are afforded the opportunity to consent to, or deny the release of, identifiable medical or other information except as required by law.

Organization

- An individual record is maintained for each Member. Each medical record will be individualized, the format standardized, and will be organized and secure.

Availability

- Each medical record is filed and stored in a central place (restricted from public access) utilizing a standardized and centralized tracking system, assuring ease of retrieval, availability and accessibility as well as confidentiality.

Retention and Destruction

- Member medical information and records are stored in an anonymous manner and are disposed of or destroyed in a way such that information is not identifiable.
- Medical records shall be retained, in accordance with the Agreement, to provide for continuity of patient care and to establish facts regarding the patient's condition and course of treatment, should those facts ever come into question.

Documentation

- Personal information must include name, address, date of birth, home, work or contact phone number.

- Each page of the medical record must include a unique identifier, which may include patient insurance identification number, medical record number, first and last name.
- Each medical record contains identifying information for all practitioners/Providers participating in the Member's care and information on services they render.
- All entries in the medical record contain the author's identification (may be a handwritten signature, an initials-stamped signature, or a unique electronic identifier).
- All entries in the medical record are dated.
- All entries in the medical record are legible to someone other than the writer.
- A problem list of all the Member's chronic/significant behavioral health issues must be maintained and dated. A chronic problem is defined as one which is of long duration, shows little change or is of slow progression. Absence of chronic problems must be noted on the problem list.
- Medication allergies and adverse reactions are prominently noted in the medical record. If the Member has no known allergies or history of adverse reactions, this is appropriately noted in the medical record.
- Psychotropic medications must be listed and updated as necessary with dosage changes and the date the change was made. All prescribed and over-the-counter medications taken on an ongoing basis must be noted in the medical record. The drug, dose, route, duration and quantity of all prescribed medications must be noted. Ongoing medications that have been discontinued since the last visit should be noted. *Dates of initial and refill prescriptions should be noted.*
- Past medical history (for Members seen three or more times) is easily identified and includes serious accidents, operations and illnesses. For children and adolescents (18 years of age or younger) past medical history relates to prenatal care, birth, operations and childhood illnesses.
- Current medical conditions and treatment are expected to be maintained in the record as well.
- For Members 14 years or older, there is appropriate notation concerning the use of cigarettes, ethanol and substances (for Members seen three or more times, substance abuse history is queried).
- Treatment plans are consistent with psychosocial assessment/diagnoses and care is medically appropriate. Treatment consents are appropriately documented. Risk factors for the Member relevant to the particular treatment are noted.
- Encounter notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time of return is noted in weeks, months or as needed.
- Missed/failed appointments are tracked to ensure appropriate medical care and monitor Member non-compliance. "No Show," "Rescheduled" or "Canceled" is noted in the records, as applicable. Practitioner documents intervention in the medical record.
- Member calls after hours are documented in the medical record.
- Unresolved problems from previous office visits are addressed in subsequent visits.
- There is documentation of appropriate use of Care Managers and if a consultation is requested, there is a consultant note in the medical record.
- Practitioners making referrals will transmit necessary information to practitioners receiving referrals (i.e., specialist consultant reports).
- Practitioners furnishing a referral service will report appropriate information to the referring practitioner.

- The record contains referral notes from medical practitioners to behavioral health practitioners (as applicable) and documents evidence of clinical feedback (i.e., consultation report inclusive of diagnosis, treatment plan, and psychopharmacological medication, as applicable) from the behavioral health practitioners to the medical practitioners.

Medical Records and Grievance Policy

According to our grievance policy, Anthem has only thirty (30) days to respond to a standard grievance and only seventy-two (72) hours to respond to an urgent or expedited grievance. Should the Department of Managed Health Care (DMHC) or the California Department of Insurance (CDI) determine that an issue qualifies for the Independent Medical Review Process, Anthem has three (3) days to produce medical records. To research grievances, sometimes we request medical records from the participating Facility.
! Due to the short turnaround times, we need the Facility to rapidly respond to our request.

The request will be in writing and sent via fax. Due to the short turnaround times, we need the Facility to rapidly respond to our request. Send medical records to the address indicated on the request, not the general billing address or, preferably, faxed to 1-877-487-7394 toll free.

If you have any questions, review our grievance policy, which is detailed in the *Member Grievance and Appeal Process* section of this Manual.

Billing Guidelines

Psychiatric and Eating Disorder Inpatient Services

The billing requirements for psychiatric and eating disorder inpatient services apply to each approved and medically necessary day of service in a duly licensed acute psychiatric bed, and include all services rendered during an admission, including, but not limited to: room and board, nursing care, laboratory, radiology, equipment, pharmaceuticals, all other services incidental to the admission and all other professional services. Psychiatric and eating disorder inpatient services also cover inpatient services, including, but not limited to, diagnostic imaging, lab, and 23-hour stabilization. In general, services billed should match the level of service authorized. Any discrepancy in revenue code billed and level of service authorized will most likely result in a claim delay.

Substance Abuse Residential Rehabilitation Services

The billing requirements for substance abuse residential services apply to each approved and medically necessary day of service in a duly licensed, distinct part of a substance abuse treatment unit, and cover payment for all services rendered during an admission, including, but not limited to: room and board, nursing care, laboratory, radiology, equipment, pharmaceuticals, all other services incidental to the admission and all other professional services. The requirements also apply to days of service for alcohol/substance detoxification, rehabilitation and aftercare.

Psychiatric and Eating Disorder Outpatient Services

The billing requirements for psychiatric and eating disorder outpatient services apply to each approved and medically necessary date of service in a licensed psychiatric outpatient program, and cover payment for all services rendered during a psychiatric outpatient visit, including, but not limited to: Facility use,

laboratory, radiology, supplies, equipment, pharmaceuticals, all other services incidental to the outpatient visit and all professional services. A psychiatric outpatient visit means a single date of service.

Substance Abuse Outpatient Services

The billing requirements for substance abuse outpatient services apply to all Medically Necessary days of service in a licensed substance abuse treatment program, and include payment for all services rendered during a substance abuse outpatient visit, including, but not limited to: Facility use, laboratory, radiology, supplies, equipment, pharmaceuticals, all other services incidental to the outpatient visit and all professional services. Aftercare treatment is also included.

Anthem Blue Cross has created levels of care for this service category, and they differ in terms of the degree of services required. For billing purposes, these levels are defined by the ICD-9-CM diagnosis code billed to Anthem Blue Cross.

Definition of Levels of Care

- Level 1 – Includes Intensive Outpatient Programs (IOP) (3–5 hours/3 days per week, minimum).
- Level 2 – Includes Partial Hospitalization (PHP) (6–8 hours per day/5 days per week), and outpatient detoxification.

Billing Requirements

1. Diagnosis Codes – ICD-10 diagnosis codes must be included for each care level. Refer to the current ICD-10 Manual for the appropriate diagnosis codes.
2. Revenue codes – Refer to your Agreement Fee Schedule Exhibit for applicable revenue codes.
3. Utilization Review must approve the level of care for all services where required. The authorization number is required for each claim. Indicate the authorization number in field 63 on the UB-04 Claim.
4. Each date of service must be billed on its own line.

Summary of Material Changes

The Summary of Material Changes table provides a summary of new and updated information for this year's revision of the Manual, and is organized by section. While the summary will help you locate the 2016 changes, it **does not** contain all of the details that you need to know. Refer to the appropriate section of this Manual to become familiar with any new requirements that are effective on **March 1, 2017**.

Section	Subsection	Change
Introduction and Guide to Manual	Using This Manual	• Effective date of changes: March 1, 2017 • Any reference of Member also means "Covered Individual".
Introduction and Guide to Manual	Blue Card Program,	• For information specific to BlueCard please see section BlueCard and the BlueCard Provider Manual, online at anthem.com/ca > Providers > Enter > Communications > BlueCard® Program Provider Manual.
Introduction and Guide to Manual	Federal Employees Benefits Health Program	• For information specific to Federal Employee Program (FEP) see section *Federal Employees Health Benefits Program* section of this Manual.
Introduction and Guide to Manual	Medicare Advantage	• For information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider.
Introduction and Guide to Manual	Transplant	• For information specific to transplant please see section Centers of Medical Excellence and the *Anthem Centers of Medical Excellence (CME) Transplant Network Contract Operations Manual* which can be found in the *Exhibits* section.
Introduction and Guide to Manual	Future Updates	• Revised 1st paragraph added, "Anthem will send a 90-day Provider notification and publish the most current procedures and policies as an "Update to the Manual" on ProviderAccess." Anthem will make every effort to include the update in the next Manual update. • Added 2nd paragraph, "IMPORTANT UPDATE REGARDING PROVIDERACCESS®… " • Added 3rd paragraph, " Visit availity.com… "

Summary of Material Changes

Section	Subsection	Change
Legal and Administrative Requirements Overview	SB 137 Anthem Provider Directory	• Added subsection
Legal and Administrative Requirements Overview	Misrouted Protected Heath Information (PHI)	• Revised last sentence Network Relations contact information revised **CAContractSupport@Anthem.com**
Legal and Administrative Requirements Overview	Contractual Requirements	Revised: Subsection: Insurance Requirements Added: For Ambulance/Medical Transportation Providers Only, in addition to the above: • Auto Liability insurance which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render services, but at no time shall total limits be less than $500,000 combined single limit. For Air Ambulance Providers Only, in addition to the above: • Aviation Liability insurance with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate. Revised: • "Acceptable self-insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured network/Participating Provider shall maintain…" Revised: • Line items #1, #2 and #3 • Line item B added revised last sentence
Legal and Administrative Requirements Overview	Risk Adjustments	• Added subsection
Directory of Service	Entire Section	• Revisions throughout this section • Behavioral Health Network Relations team e-mail address: BHNetworkRelations@anthem.com

Summary of Material Changes

Section	Subsection	Change
Directory of Service	Entire Section	• ProviderAccess…"! IMPORTANT UPDATE REGARDING PROVIDERACCESS® Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). **This change does not affect the anthem.com/ca public website…"** • Stop Loss…"Effective January 1, 2017, the Anthem Blue Cross' (Anthem) Hospital Stop Loss Customer Service number, 1-818-234-3603, will be discontinued. After this date, you will no longer be able to reach a person or leave a voice message…"
Availity Web Portal (Availity)®	Entire Section	• Revisions throughout this section Added: • ! IMPORTANT UPDATE REGARDING PROVIDERACCESS® Anthem is targeting January 20, 2017, to retire ProviderAccess and all functionality will move to the Availity Web Portal (Availity). This change does not affect the anthem.com/ca public website. • "If you currently use ProviderAccess tools such as fee schedules, online remits, reports or for accessing manuals or helpful administrative information, registration for Availity is required to access these tools in the future. Prepare now by registering on Availity…"
Eligibility	Mobile Health Care Identification Cards (HCID Cards)	Added: • "To provide increased convenience, Anthem, members can provide their ID card through a traditional printed version, or through our Anthem app on a phone or mobile device. Through the app, the card will look and works just like a printed one. Members can show, email, or fax their HCID card to providers. The mobile HCID card includes the member's ID number, copays, Anthem phone number and address and all other information on the printed version.

Summary of Material Changes

Section	Subsection	Change
Claims Submission	General Billing Requirements	Revised: • Line item #6. For Federal Employee Members, submit to the following address: Anthem Blue Cross Federal Employee Program P.O. Box 105557 Atlanta, GA 30348-5557 Added: • Line item #20. Anthem Rate Requiring billing of specific DX code(s)
Claims Submission	Hospital Stop Loss Inquiry Customer Service Number Discontinued	• Added subsection
Claims Submission	Researching a Stop Loss Claim	Revised: • "Claim status inquiry is available through Availity. Login to availity.com. From the top of the page, select the Claims tab and choose Claims Status Inquiry from the drop-down menu. For questions about a claim, we offer an easy, online…"
Claims Submission	Electronic Data Interchange	Revised: • Contacting the EDI Solutions Help Desk 1-800-470-9630 (toll free) • ERA/EFT 1-800-470-9630 (toll free) • Getting Connected with Electronic Attachments when filing electronic Claims to Anthem, contact Vyne Medical toll-free at 1-888-329-9988 option 2.
Claims Submission	Tips for Clean Paper Claim Submission	Revised subsection: • "Availity Web Portal (Availity). Availity provides the opportunity to "ask a question" about a claim on-line. You can send a detailed question to clarify the status…"
Claims Submission	Information for Contracted Providers – Claims Settlement Practices	Revised: • Line item #4 Claim receipt verification. "Claim status inquiry is available through Availity. Login to availity.com, select Claims tab…"

Summary of Material Changes

Section	Subsection	Change
Claims Submission	Information for Contracted Providers – Claims Settlement Practices	Revised Claim Overpayments • Line item #4. Offsets to payments
Claims Submission	Overpayment Recovery Procedure	• Revised subsection
Claims Submission	Secure Messaging – Availity	• Added subsection
Claims Submission	Billing Instructions and Requirements by Service Category for Hospital/ Facility	Revised: • 2. Maternity and Boarder Baby Care Billing instructions and requirements: Line item #2. " ICD-10-CM procedure codes must be included…"
Claims Submission	Billing Instructions and Requirements by Service Category for Hospital/ Facility	Revised: • 5. Chemical Dependency Inpatient Services Billing instructions and requirements: Line item #1. " ICD-10-CM diagnosis codes must be included for each care level. The appropriate ICD-10-CM codes are…" • 7. Chemical Dependency Outpatient/ Residential Services Level 2 Billing instructions and requirements: Line item #1. ICD-10-CM diagnosis codes must be included for each care level. The appropriate ICD-10-CM codes are…" • 10. Urgent Care Visits, 1st paragraph, "The billing requirements for urgent care visits apply to all urgent care cases initially treated…"
Reimbursement Policies	Place of Service and Evaluation & Management Facility Reimbursement Policy	• Added subsection
Reimbursement Policies	3D Rendering of Imaging Studies Facility Reimbursement Policy	• Added subsection
Medical Management Program	Utilization Management (UM)	• Revised subsection
Medical Management Program	Electronic Data Exchange	Added: • Interactive Care Reviewer (ICR) subsection

Summary of Material Changes

Section	Subsection	Change
Credentialing	Entire Section	• Revisions made throughout this section
Quality Improvement	Entire Section	• Revisions made throughout this section
Cultural Diversity and Linguistic Services	Entire Section	• New section
Health and Wellness	Entire Section	• Health and Wellness (formally referred to as 360° Health) • Revised section
Centers of Medical Excellence	Centers of Medical Excellence	• Revised subsection
Member Grievance and Appeal Process	Anthem Blue Cross HMO/POS/PPO Grievance Process	• Revised subsection
Member Grievance and Appeal Process	Medicare Advantage	Added: For information on Medicare Advantage refer to the Medicare Advantage Provider website at anthem.com/ca/medicareprovider. Medicare Advantage Provider Manuals are available on the Medicare eligible website at Medicare Advantage HMO & PPO Provider Guidebook. Or, refer to the Medicare Advantage section of this Manual.
Dispute Resolution Process for Contracted Providers	Dispute Resolution Process for Contracted Providers	Revised: • Line item #2 Secure Messaging – Availity Web Portal (Availity • Line item #2d, 2e, 2f, 2g and 2h • Line item #3 Sending a Contracted Provider Dispute to Anthem • Line item #4b "In the case of inaction, contracted Provider disputes must be…"
Dispute Resolution Process for Contracted Providers	Meet and Confer	Revised: • Submit all requests for a meet and confer to the following address: Legal Department Attn: Meet and Confer Request Anthem Blue Cross 21555 Oxnard Street, AC1C Mailstop CAAC01-001B Woodland Hills, CA 91367

Section	Subsection	Change
Dispute Resolution Process for Contracted Providers	Independent Review Organization Dispute Resolution Process for Medical Necessity Disputes	Revised: • 1st paragraph last sentence, "If the claim in dispute is not one where Anthem Blue Cross performs…"
Dispute Resolution Process for Contracted Providers	Independent Review Organization Dispute Resolution Process for Medical Necessity Disputes	Revised: • Line item #5, "All submissions made pursuant to this section shall be made within the time …"
Dispute Resolution Process for Contracted Providers	Dispute Resolution and Arbitration	Revised: • Line item C .Selection and Replacement of Arbitrator(s). • Line item F. Confidentiality Revised: Provider Appeal Guidelines subsection All contracted Provider disputes for FEP should be sent to the following address: Anthem Blue Cross Attn: FEP P.O. Box 105557 Atlanta, GA 30348-5557
Federal Employees Health Benefits Program	Entire Section	• Content was pulled from sections throughout this manual to create this new section,
BlueCard Program	Entire Section	• New section
Health Insurance Marketplace (Exchanges)	Entire Section	• New section
Audit	Entire Section	• Revisions made throughout this section
Fraud, Waste and Abuse Detection	Entire Section	• New section
Exhibits - Table of Contents	Entire Section	Add: • Notice of Privacy Practices (Moved from Appendices) • Blue Cross HMO – ID Card Sample • Covered CA (Health Insurance Exchange) ID Card Sample

Summary of Material Changes

Section	Subsection	Change
Exhibits - Table of Contents	Entire Section	Moved: • Severity Levels for Quality Assurance (moved to Member Grievance and Appeal Process section) Revised: • Anthem Centers of Medical Excellence(CME) Transplant Network Contract Operations Manual • BlueCard® Contact List • Continuity of Care/Transition of Care Request Form • Member (Patient) Responsibility Agreement • Facilities Census Feed File Format • Preventive Health Guidelines • Provider Dispute Resolution Request • Timely Filing Acceptable Forms of Proof Removed: • Claims Re-process/Inquiry Form • Cultural Diversity and Linguistic Service • Electronic Self-Service Options • Provider Claim Escalation Process
Appendix A – Other Payors List (Network Leasing)	IMPORTANT UPDATE REGARDING PROVIDERACCESS®	Added: • IMPORTANT UPDATE REGARDING PROVIDERACCESS®
Links	Entire Section	• Revisions made throughout this section
Workers' Compensation	Entire Section	• Revisions made throughout this section
Dialysis Facilities	Services Definitions	Added: • CPT/HCPCS Code (to the table)
Behavioral Health and Substance Abuse	Follow-up Referrals within 7 Days after Discharge	• Medical Management Services replaced Outreach Care Services
Summary of Material Changes	Entire Section	• Revised

Anthem Centers of Medical Excellence ("CME")
Transplant Network

CONTRACT OPERATIONS MANUAL
for

TRANSPLANT PROGRAM

A supplemental document to the
Anthem Blue Cross Manual

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ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION I
Scope

Unless otherwise expressly indicated in this Operations Manual, all terms used shall have the meaning in the Stand Alone Agreement or Transplant Attachment to the Anthem Blue Cross Hospital Agreement.

The Anthem CME for transplant consists of a network of approved providers and facilities (the "Network") for the following transplant procedures: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas. Individual transplant procedures (i.e. heart, lung or combination heart/lung) are referred to in this Manual as a "Program".
The following list of Anthem Blue Cross products will have access to the Network:
The following list of Anthem products will have access to the Network:

- HMO (includes group HMO and POS products such as: HMO Program, POS Program, Select HMO)
- PPO (includes PPO, EPO and CDHP products such as: PPO Program, Select PPO)
- Indemnity/Traditional/Standard (includes products such as: Traditional)
- Government Programs: Medicare Advantage and Senior Select

All Anthem Blue Cross Covered Individuals, including local, national and Affiliates, have Network access under the terms of the Stand Alone Transplant Agreement or Transplant Attachment to the Hospital Agreement between you and Anthem Blue Cross, attached hereto and incorporated herein.
Please refer to your contract for specific information to product type and exceptions.

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SECTION II
QUALITY OVERSIGHT OF THE ANTHEM CME NETWORK

The Anthem CME transplant certification procedures are designed to ensure Covered Individuals, that all Network transplant centers meet Company established clinical criteria and levels of service. Participating transplant centers are selected based on their ability to meet defined clinical criteria that are unique for each transplant type.

To Begin the Certification Process

To initiate the transplant certification process for programs not currently in the Network, prospective applicants should contact their respective Anthem Blue Cross Contract Manager and express your interest. The Anthem Blue Cross Contract Manager will notify the Anthem CME Quality Oversight Department to begin the certification process.

Initial Application and Re-certification

Each prospective transplant center is evaluated independently against established criteria via a Request for Information (RFI) survey. Upon written request, prospective solid organ transplant centers, will submit data using the current online version of the United Network for Organ Sharing (UNOS) Standardized RFI forms. Access to the secure data entry site can be obtained by contacting UNOS. Prospective bone marrow/stem cell centers will submit data using the current American Society for Blood and Marrow Transplant (ASBMT) Standardized RFI forms which can be accessed at www.asbmt.org

Quality Review Process

The Anthem CME quality review process for participation in the transplant network will include evaluation of selection criteria that encompass, but are not limited to, the following:

Solid Organ Transplant Programs	Bone and Marrow Transplant Programs
1. Volume (by transplant type);	1. Volume (by transplant type);
2. 1-month, 1-year and 3-year patient and graft survival;	2. 100-day and 1-year patient survival;
3. Transplant rate;	3. Percent follow-up;
4. Mortality rate while on the waitlist rate;	4. Transplant team composition, stability;
5. Percent follow up;	5. FACT Accreditation;
6. UNOS Certification	6. CIBMTR data submission

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SECTION II
QUALITY OVERSIGHT OF THE ANTHEM CME NETWORK
Continued

Each program is reviewed by the Company's National Transplant Quality Review Committee (NTQRC). The NTQRC is comprised of transplant experts from across the country. There are two committees: one for solid organ transplants and one for blood and marrow transplants. No less than annually, the certification criteria and benchmarks are reviewed and approved by each committee.

Annual re-certification and on-going monitoring of outcomes data assures transplant programs continue to meet applicable Network participation requirements.

Appeal Process

Health care facilities or programs that are not accepted for participation in the network or which are terminated from the Network will be provided the reconsideration or appeal process described in the Anthem Hospital Provider Manual.

Health care facilities or programs that are terminated from the Network will be provided the reconsideration or appeal process described below:

Anthem CME will provide a one-level reconsideration process for currently designated health care facilities or programs that are terminated from the Anthem Centers of Medical Excellence Transplant Network if an appeal is submitted in writing to the Anthem Centers of Medical Excellence Quality Program Manager at the address listed below within thirty days of the date of receipt of the termination letter. The program's written appeal must include the reason why the facility or program should be r econsidered and any corrected/completed data or supporting documentation related to the reason for the appeal. The written appeal information will be reviewed by the National Transplant Quality Review Committee (NTQRC) at its first scheduled meeting following receipt of the appeal and the program will be notified of the appeal review determination via electronic mail and/or UPS mail delivery. The appeal determination is final.

Send Appeal Letter to:
Anthem CME Program Manager
3350 Peachtree Rd. NE
GAG006-0005
Atlanta, GA. 30326

Provider Responsibility

As a participation provider in the Anthem CME transplant network, each center agrees to immediately report major changes in its team or program structures, its federal rating status (such as loss of Medicare certifications) or any event that could result in failure to satisfy the criteria for participation in the network. A ll health care professionals are required to refer patients to an Anthem approved facility, unless there is a medical reason for referring the patient to a non-approved transplant facility.

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SECTION III
TRANSPLANT CARE MANAGEMENT PROGRAM

The procedures outlined below must be followed for each transplant in order to determine Medical Necessity

To Initiate the Member's Transplant Pre - Authorization Review Call:
Phone Number: 1-888-574-7215
Fax: 1-866-255-2471

To Contact the Member's Transplant Case Manager Call:
Phone Number: 1-888-574-7215
Fax: 1-866-255-2471

Identification

Cases are identified to the Case Management Program primarily through referrals from our other medical management programs, the pre-service certification/concurrent review process or from other referral sources such as family, physician, hospital personnel and Company representatives. Cases that meet certain criteria are referred to a transplant case manager for proactive intervention when appropriate.

Non-transplant pre-certification

Please refer to the Anthem Blue Cross Hospital Agreement Provider Manual.
[Please call Customer Service using the phone number listed on the back of the Covered Individual's insurance card for pre-certification requirements for non-transplant services.]

Transplant Review Process

Pre-transplant or Pre-admission [Prior Authorization] Review Process for Transplant. The transplant provider must submit to Anthem a request for transplant authorization and the Covered Individual's clinical records to support this request. Anthem will conduct a review to determine whether a scheduled admission, transplant or transplant services are Medically Necessary. Such review is required for all non-emergent admissions and transplants.

Pre-service Review. For all Covered Individual specific transplant information, please contact customer services and ask for the transplant case manager. Pre-service review determines whether the scheduled outpatient and/or ambulatory procedures are Medically Necessary. Services that may be subject to pre-service review include, but are not limited to, the following:

- Pre-transplant evaluation and work-ups
- Donor search and HLA testing (when applicable)
- Marrow/stem cell harvesting collection, modification and/or storage (when applicable)
- Other pre-transplant and post-transplant services provided to the Covered Individual outside of the Global Case Rate Period and/or rendered on an outpatient bases.

Medical Necessity Review Process. The transplant case manager reviews and determines the appropriateness of the diagnosis, the type of transplant requested the referral for transplant, and the Covered Individual's eligibility. After the initial review of the submitted medical records which include the transplant evaluation results, the transplant case manager contacts the CME facility if additional information is required to authorize the requested procedure. Once medical necessity is established, authorization letters are sent to the transplant physician, CME facility and the member. When admission for transplant occurs, the COE facility contacts the assigned transplant case manager for ongoing case management.

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SECTION III
TRANSPLANT CARE MANAGEMENT PROGRAM
Continued

Re-certification. For Covered Individual's on a transplant waitlist, regular and ongoing updates and reviews are performed on a case-by-case basis with the COE facility, and will take place no less than once a year. Benefits and eligibility will be checked and verified at these intervals. A written confirmation of the updated authorization will be sent via the U.S. mail.

Concurrent Review. Determines whether a continued inpatient stay is Medically Necessary. Such reviews are required for all Covered Individuals during a hospital stay for the actual transplant procedure

Retrospective Review. When pre-certification was not performed prior to the transplant evaluation or the transplant procedure, a thorough review will be done by the transplant case manager to determine if services were Medically Necessary. (Some penalties may apply. Call customer service for more information regarding penalties.)

Member Appeal Process.
Please refer to the appeal process described in the Anthem Blue Cross Hospital Provider Manual.

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ATTACHMENT Form A1
TRANSPLANT SERVICES NOTIFICATION FORM

- **Use the tab key to go from field to field**
- **Remember to print and sign this form**

FEP Member ☐ State of Residence _____ Non FEP Member ☐

Referring Anthem Plan

Patient Name | Patient ID #
Date of Birth

Group Name / ID Number | Subscriber Name / ID Number

Primary Insurance Carrier Name | Secondary Insurance Carrier Name

TRANSPLANT TYPE: (please check all that apply)

BONE MARROW/STEM CELL **Patient Diagnosis:** _____

Type: Autologous ☐ Allogeneic ☐ "Mini" Allogeneic ☐ Tandem: #1 ☐ Tandem: #2 ☐

Cell Source: Bone Marrow ☐ Peripheral Blood Stem Cell ☐ Cord Blood ☐

Donor (If Allogeneic): Related ☐ Unrelated ☐ Matched ☐ Mismatched ☐

SOLID ORGAN **Patient Diagnosis:** _____

Organ Type: _____ Initial Transplant ☐ Re-transplant ☐ **Donor:** Cadaveric ☐ Living Donor ☐

Transplant Hospital Name | Transplant Hospital Address

This patient meets the Medical Necessity guidelines of _____ (name of Anthem Plan) for the above noted transplant, for included Transplant Service. All eligible Transplant Services and Global/Outlier Rates are listed in the Centers of Medical Excellence Hospital Participation Agreement.

Contact: _____ at _____ for precertification and to verify continued eligibility for medical benefits prior to beginning CME Transplant Services.

Authorized Plan Representative Signature | Title | Expiration Date

Print Name | Area Code + Phone Number | Fax Number

Contact: _____ at _____ For Case Management Services

Hospital: Submit bundled, GLOBAL CLAIM (including the CME Attachment C or D), and a copy of this CME Attachment A1 – Transplant Services Notification Form to:

Name | Address | Phone Number

(Please reconfirm this Plan claim contact information prior to submitting bundled global claim. Hospital is to collect any applicable coinsurance, deductibles, and co-payments.)

Plan: Provide any additional information or special instructions below (i.e., LTM, COB, deductibles, co-payments, COB for FEP, etc.):

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ATTACHMENT Form A2
HOSPITAL NOTIFICATION OF TRANSPLANT ADMISSION FORM

Date _____ FEP Member ☐ Non FEP Member ☐

Non FEP Member
To: Transplant Claim Unit Fax #: 866-255-2471
Phone #: 1-888-574-7215

FEP Member
To: FEP Transplant Unit outside of California Fax #: 866-255-2471
Phone #:1-888-574-7215

From:

Name: _____ Institution: _____

Phone#: _____ Fax #:_____

_____
Patient Name Patient ID # Date of Birth

Referring Blue Cross and Blue Shield Plan (or FEP Servicing Plan)

NOTE: Please complete a separate Hospital Notification of Transplant Admission Form for each Transplant.

Solid Organ Transplant

Solid Organ Type: _____ Diagnosis: _____

Initial Transplant ☐ Re-transplant ☐ Cadaveric ☐ Living Donor ☐
Inpatient Admission Date: _____ Inpatient Transplant Date _____
Anthem CME Dates: _____ to _____

Bone Marrow / Stem Cell Transplant

Diagnosis: _____
Check all that apply:
Autologous ☐ Allogeneic ☐ Mini Allogeneic ☐ Tandem #1 ☐ Tandem # 2 ☐
Bone Marrow ☐ Peripheral Stem Cell ☐ Cord Blood ☐
Related ☐ Unrelated☐ Matched ☐ Mismatched ☐

Mobilization Therapy Date(s): Inpatient _____ Outpatient _____
Marrow/Stem Cell Harvesting Date(s): Inpatient_____ Outpatient _____
Marrow Ablative Therapy Date(s): Inpatient _____ Outpatient _____
Reinfusion/Transplant Date(s): Inpatient _____ Outpatient _____
Anthem CME Dates: _____ to _____

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ATTACHMENT FORM B
PATIENT DISCHARGE FORM CARE NOTIFICATION FORM

Date: _____ FEP Member ↑ Non FEP Member ↑

Patient Name: _____ ID#: _____

Referring Plan (or FEP Servicing Plan): _____

Date of Transplant: _____ Type of Transplant: _____

Anthem CME Dates: _____ to _____

Institution: _____ Date of Discharge: _____

Hospital:	**Referring Plan (or FEP Servicing Plan)**
_____ (Signature)	_____ (Signature)
_____ (Print Name)	_____ (Print Name)
_____ (Title)	_____ (Title)
_____ (Date)	_____ (Date)

After Completion of Form: Fax one copy to the Referring or FEP Servicing Plan's Transplant Coordinator. Refer to the Referring and Servicing Contact List in the Procedure Manual. Keep one copy for your records.

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SECTION IV
ANTHEM CME TRANSPLANT CELL DESCRIPTIONS

Cell 1 includes **evaluation** and all transplant services that are Covered Transplant services required to assess and evaluate the Covered Individual for acceptance to the transplant program. Cell 1 ends with the acceptance and listing on UNOS for solid organ recipient or the non-acceptance of a Covered Individual into the transplant program. For bone marrow/stem cell transplants, Cell 1 ends with the acceptance or non-acceptance of the Covered Individual into the transplant program

Cell 2 includes **pre-transplant care** and all transplant services that are Covered Transplant Services provided to a Covered Individual following acceptance into a Hospital transplant program or Covered Individual's listing with UNOS, until one day prior to the Covered Transplant Procedure. Cell 2 charges related to pre-transplant care end one day prior to the Covered Transplant Procedure. For solid organ transplants this means the end date is two days prior to the Covered Transplant Procedure and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are Covered Transplant Procedures.

Cell 3 includes the **Covered Transplant Procedure** provided to a Covered Individual. For solid organs the Covered Transplant Procedure begins the day prior to the transplant or for bone marrow begins the day prior to high dose chemotherapy or preparative regimen and ends at the end of the global case rate period or if the covered individual is still inpatient at the end of the global case rate period on the date of discharge from the inpatient stay. If days for inpatient admission for the solid organ or bone marrow transplant exceed the Global Case Rate Period for Transplant, the reimbursement will revert to the Outlier Per Diem Rate for Transplant for all days outside of the Global Case Rate Period, until the date of discharge from inpatient stay.

Cell 4 follow up care includes all Covered Transplant Services provided to a Covered Individual during the six (6) months following the end of Cell 3 for solid organ transplants and fifty (50) days following the end of Cell 3 for a bone marrow/stem cell transplant.

Covered Transplant Services Inclusions for the Four Transplant Cells (use only if this information does not appear in the attachment to your contract) For the purposes of this agreement only Cell 3 is applicable. Cells 1, 2 and 4 will be covered under the terms of the Anthem Local Agreement.

Cell 1: All Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 1 Case Rate and will not be unbundled and billed to a Covered Individual. Covered Transplant Services include the transplant-related health care services and supplies that are provided by Hospital, Group and its Physicians, or other health care professionals who are either employees of Hospital or are subcontracted by Hospital to provide certain services to Covered Individuals; and are provided under the supervision of Hospital and/or the Medical Group and Physicians.

1. Diagnostic testing, including without limitation, evaluation services, HLA typing, and diagnostic testing to determine eligibility or disease stage (if applicable).
2. Donor services, including donor identification, living donor health care services and supplies relating to donation, bone marrow registry charges, Billed Charges, donor search and identification (if applicable).

Cell 2: All Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 2 Case Rate and will not be unbundled and billed to a Covered Individual.

Cell 2 includes pre-transplant care and all transplant services that are Covered Transplant Services provided to a Covered Individual following acceptance into a Hospital transplant program or Covered Individual's listing with UNOS, until one day prior to the Covered

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Transplant Procedure. Cell 2 charges related to pre-transplant care end one day prior to the Covered Transplant Procedure. For solid organ transplants this means the end date is two days prior to the Covered Transplant Procedure and for bone marrow/stem cell transplants, the end date is two days prior to initiation of the preparative regimen for autologous and for allogeneic transplants that are Covered Transplant Procedures.

Cell 3 Inclusions: All Covered Transplant Procedures, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 3 Global Case Rate for Transplant and will not be unbundled and billed to a Covered Individual.

1. Anesthesiology services and supplies.
2. Bone marrow/peripheral blood stem cell (or cord blood) mobilization and harvesting related services (including preparation, transportation, storage and administration) and complications, regardless of when these services occur before transplant (if applicable)
3. Living donor is considered to be a person who donates an organ, part of a solid organ, kidney, liver, lung or bone marrow/stem cells while alive to another person. Covered Services for living donor donation would include Health Services and Medical Services for the donor for up to 30 days after the date of donation.
4. Inpatient rehabilitation services and supplies when Covered Individual is transferred to an inpatient rehabilitation unit post-transplant. Days do not count toward the Global Case Rate Period for Transplant.
5. Inpatient services provided during Cell 3 – all medically necessary services are included in the Transplant Rate, including dialysis (if applicable), room, board and supplies, and pharmaceutical agents and supplies. Nothing is excluded.
6. Organ procurement and transport, including procurement and transport that occurs outside of Facility's service area for all solid organ transplants.
7. Outpatient drugs, supplies and biological agents that are pre-transplant, treatment specific for preparing Covered Individual or Donor for transplant procedure.
8. Outpatient drugs, supplies and biological agents that are given to Covered Individual during the transplant process.
9. Outpatient services provided in Cell 3 – all services are included, including rehabilitation services and supplies, biopsies and laboratory.
10. Preparative regimen for bone marrow, cord blood or stem cell transplant, including chemotherapy, radiotherapy or chemo-radiotherapy (if applicable).
11. Donor leukocyte/lymphocyte infusion post-transplant for boosting engraftment of bone marrow/stem cells if provided while Covered Individual is in Cell 3

Cell 4: Covered Transplant Services, including but not limited to the items listed below, that are provided to a Covered Individual are included in the Cell 4 Global Case Rate Period.

1. Includes all outpatient transplant-related follow-up care for the recipient.
2. Medically Necessary inpatient services.
3. Ancillary services (i.e. home health care services and supplies) provided by Hospital Medical Group or subcontracted providers.
4. Outpatient pharmacy and laboratory are excluded.

Covered Transplant Services Exclusion: the services below delivered during the Global Case Rate Period for Transplant are excluded from the Global Case Rate for Transplant. Excluded Covered Transplant Services will be reimbursed according to the terms of the Anthem Facility, Professional or Ancillary Agreements with Providers.

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1. Pre Transplant Services prior to the start of the Global Transplant Period
2. Post Transplant Services after the end of the Global Transplant Period and any applicable Outlier Period.

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SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES

General Global Billing Guidelines for the Four Transplant Cells

Cell 1 Processing Guidelines (if applicable)
These services will be reimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement

Cell 2 Processing Guidelines (if applicable)
These services will be r eimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement.

Cell 3 Processing Guidelines
At the end of the Global Case Rate Period for Transplant or Outlier Period for Transplant (if applicable) the HOSPITAL (Provider) will collect all itemized bills (UB 04's and CMS 1500 claim forms) for all inpatient and outpatient-Hospital, Professional, and Ancillary charges included in the Global Case Rate, and outlier rate (if applicable).

All eligible Transplant Services and applicable rates are listed on the compensation schedule. (See Appendix B)

A bundled claim packet should not include claims from the following

- Charges for specifically excluded services noted on the compensation schedule of the Anthem CME Transplant Agreement
- Charges before the Global Case Rate Period for Transplant begins
- Charges after the Global Case Rate Period for Transplant and/or after any applicable Outlier Period for Transplant.

Mail the bundled Cell 3 Global Case Rate Period claim packet with the proper Billing Summary Form (See Appendix A) in one envelope to the claim address listed above. Failure to include the Billing Summary
Form may result in delayed correct payment. F orm C should be i ncluded with solid organ transplant bundled claims. Form D should be included with bone marrow transplant bundled claims.

Cell 4 Processing Guidelines (if applicable)
These services will be r eimbursed according to the terms of the current Anthem Facility Agreement and the current Anthem Professional Agreement.

Special Billing Instructions

Claim processing:
All claims are processed according to the benefit level in effect at the time the services are rendered.

Living Donor Charges (if applicable):
Claims for living donor charges should be filed with the correct procedure codes and donor diagnosis codes based on the type of service that was rendered to the Covered Individual. Claims should be filed with the recipient's insurance.

BlueCard Program-Cell 3 Transplant Services:
Transplant services for non-Anthem Covered Individuals utilizing the Blue Card system should be submitted in the same manner as non-transplant claims

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SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Coordination of Benefits:
Coordination of Benefits for the transplant recipient is the responsibility of the provider on initial contact. Claims will be denied for payment if Anthem Blue Cross is not the primary insurance coverage and there is not an Explanation of Benefits attached from the primary insurance carrier.

Blue-on-Blue Coverage:
Covered Individuals with coverage through Anthem Blue Cross as primary and secondary payer will have claims processed according to the benefits of each contract. Claims will be filed with the primary coverage and processed based on the benefit guidelines of that Health Benefit Plan. The claim will then be filed with the secondary coverage and processed based on the benefit guidelines of that Health Benefit Plan. B enefits could be processed at different benefit levels based on the contract.

Compensation Schedule
The Compensation Schedule provides information specific to each individual transplant type. The information includes Cell 3 Global Case Rates and the Transplant Services included and excluded during the Global Case Rate Period, which may also include applicable outlier period or pre-transplant period timeframes.

Please contact your Contract Manager for your current Provider Compensation Schedule.

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SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Sample Coding (not all inclusive, samples only):

Solid Organ

Transplant Type	CPT Code	ICD-10 Code ***For dates of service on or after 10/01/2015***
Heart	33945 Heart transplant, with or without recipient cardiectomy	02YA0Z0 Transplantation of heart, allogeneic, open approach
Lung	32851 Lung transplant, single; without cardiopulmonary bypass	0BYK0Z0-0BYK0Z1 Transplantation of right lung, open approach [allogeneic, syngeneic]
Liver	47135 Liver allotransplantation; orthotopic, partial or whole, from cadaver or living donor, any age	0FY00Z0 Transplantation of liver, allogeneic, open approach
Kidney	50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy	0TY00Z0 Transplantation of right kidney, allogeneic, open approach
Pancreas	48554 Transplantation of pancreatic allograft	0FYG0Z0 Transplantation of pancreas, allogeneic, open approach
Organ Acquisition	810-819 (revenue code)	

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SECTION V
ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Sample BMT/Stem Cell Coding:

Transplant Type	CPT Code	ICD-10 Code ***For dates of service on or after 10/01/2015***
Autologous	38206 Blood-derived hematopoietic progenitor cell harvesting autologous	
	38232 Bone marrow harvesting for transplantation; autologous	
	38241 Hematopoietic progenitor cell (HPC); autologous transplantation	30230G0-30263G0 Transfusion of autologous hematopoietic stem cells [by site and approach]
Allogeneic	38205 Blood-derived hematopoietic progenitor cell harvesting allogeneic	
	38240 Hematopoietic progenitor cell (HPC); allogeneic transplantation per donor	
		30230G1-30263G1 Transfusion of non-autologous bone marrow
		30230Y1-30263Y1 Transfusion of non-autologous hematopoietic stem cells [by site and approach
		30230X1-30263X1 Transfusion of non-autologous cord blood stem cells [by site and approach

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Donor Services

Services rendered to transplant recipients and donor(s) are reimbursable only if the transplant recipient is enrolled and eligible for Anthem coverage on the date the services are performed.

When billing for services rendered to the transplant donor, providers enter the donor's name on the claim but the recipient's date of birth, sex and Anthem ID number.

Donor ICD 10 and Revenue Codes Bone Marrow/Stem Cell/Cord Blood and Solid Organs

Code	Definition	Submission Note
Bone Marrow/Stem Cell/Cord Blood		
Z52.001	Unspecified Donor, stem cells	NMDP Invoice Submitted Separately from Recipient Claim
Z52.008	Lymphocytes	UB or NMDP Invoice
0819	Other Organ Donor	Stem cell acquisition
Solid Organ		
0811	Living Donor	Line Item on UB on Recipient Transplant Admission Claim
0812	Deceased Donor	Line Item on UB on Recipient Admission Claim
0813	Unknown Donor	Kidney Paired Exchange programs

Z52.000 is the code for whole blood; be sure to reflect the correct modifier when infusion represents BM/Stem Cell or Cord Blood products.

Key fields

UB box 8b – Donor's name

UB box 58 – Insured's name

UB box 59 – Relationship code of 39 or 40

UB box 80 – Remarks noting this is a donor claim submission

HCFA box 19 – Insured's name

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FORM C
BILLING
SUMMARY FORM
SOLID ORGAN TRANSPLANT

Initial Form ☐ Additional Form ☐ Revised Form ☐ Date Revised:_____

Patient Name_____ **ID#**_____
DOB_____
Transplant Hospital_____
Payment Address:_____
_____

Transplant Type _____ **Initial Transplant ☐ Retransplant ☐ Cadaveric ☐ Living Donor ☐**

PRE-TRANSPLANT PERIOD DATES/CHARGES

Pre-transplant (Inpatient) Dates:
_____to_____

Inpatient Pre-Transplant Rate if applicable

Hospital Charges:
$_____

Professional Charges:
$_____

Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

Per Diem Rate $_____ or _____% of Charges

■ Lesser of _____% of Charges

■ Other:
_____
_____

Pre-Transplant Period Amount Due:
$_____

*Total Adjustments (attach itemization and/or claims)
$_____

Pre-transplant Period Total Adjusted Amount Due:
$_____

CASE RATE PERIOD DATES/CHARGES

Case rate period dates
_____ to _____

Transplant Date _____

Inpatient Discharge Date(s)
_____

Readmission Date(s)
_____

Organ Procurement Charges
$ _____
Hospital Charges:
$
_____
Professional Charges:
$ _____
Ancillary Charges:
$
_____
Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

Applicable Rate:
■ Case Rate Amount
$_____

■ Lesser of _____% of Charges
■ Other:
_____
_____

Case Rate Period Amount Due:
$_____
*Total Adjustments (attach itemization and/or claims)
$_____
Case Rate Period Total Adjusted Amount Due:
$_____

OUTLIER PERIOD DATES/CHARGES

Outlier (Inpatient) Dates:
_____ to
_____

Hospital Charges:
$_____

Professional Charges:
$_____

Total Billed Charges:
$_____

CASE RATE/AMOUNT DUE

■ Per Diem Rate $_____
or _____% of Charges

■ Lesser of _____% of Charges

■ Other:
_____
_____

Outlier Period Amount Due:
$_____

*Total Adjustments (attach itemization and/or claims)
$_____

Outlier Period Total Adjusted Amount Due:
$_____

***Hospital**: A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the Case Rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the Case Rate(s) agreement.*

Form Completed by
*(print name)*_____*Phone*_____*Date*_____

Plan Contact
(print name) _____*Phone*_____*Date*_____

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FORM D
BILLING
SUMMARY FORM
BONE MARROW/STEM CELL

TRANSPLANT ***Initial Form*** ☐ ***Additional Form*** ☐ ***Revised Form*** ☐ ***Date Revised:*** _____

Patient Name_____ ***ID#***_____
DOB_____
Transplant Hospital_____
Payment Address: _____
Transplant Type/Check all that apply*: Autologous □ Allogeneic □ "Mini" Allogeneic □ Tandem #1 □ Tandem #2 □ Peripheral stem cells □ Bone Marrow □ Cord Blood □ Related □ Unrelated □Matched □ Mismatched □*

PRE-TRANSPLANT PERIOD DATES/CHARGES

Pre-transplant (Inpatient) Dates:
_____*to*_____

Inpatient Pre-Transplant Rate if applicable

Hospital Charges:
*$*_____

Professional Charges:
*$*_____

Total Billed Charges:
*$*_____

CASE RATE/AMOUNT DUE

*Per Diem Rate $*_____ *or*
_____*% of Charges*

■ *Lesser of* _____*% of Charges*

■ *Other:*
_____
_____

Pre-Transplant Period Amount Due:
*$*_____

**Total Adjustments (attach itemization and/or claims)*
*$*_____

Pre-transplant Period Total Adjusted Amount Due:
*$*_____

MOBILIZATION/HARVESTING DATES/CHARGES
Mobilization Therapy Dates:
*IP*_____
*OP*_____
Mobilization Total Billed Charges:
Hospital
*$*_____
Professional
$ _____
Harvesting Date(s):
*IP*_____
*OP*_____
Harvesting Total Billed Charges:
(For Unrelated Donors, i.e., NMDP Charges)
Hospital
*$*_____
Professional
$ _____

CASE RATE DATES/CHARGES
Case Rate Period Dates: _____
*to*_____
Marrow Ablative Therapy (or Preparative Regimen Date(s) :
*IP*_____
OP _____

Transplant Date: _____

Hospital Charges:
$ _____
Professional Charges:
$ _____
Ancillary Charges:
$ _____
Total Billed Charges*:*
*$*_____
(Inc. any applicable mobilization/harvesting charge above)

CASE RATE/AMOUNT DUE
■ *Case Rate Amount*
*$*_____
■ *Lesser of* _____*% of Charges*
■ *Other:*
_____

Case Rate Period Amount Due:
(Inc. any applicable mobilization/harvesting charge above)
*$*_____
**Total Adjustments (attach itemization and/or claims)*
*$*_____
Case Rate Period Total Adjusted Amount Due:
*$*_____

OUTLIER PERIOD DATES/CHARGES

Outlier (Inpatient) Dates:
_____ *to* _____

Hospital Charges:
*$*_____

Professional Charges:
*$*_____

Total Billed Charges*:*
*$*_____

CASE RATE/AMOUNT DUE

■ *Per Diem Rate $*_____ *or*
_____*% of Charges*

■ *Lesser of* _____*% of Charges*

■ *Other:*
_____
_____

Outlier Period Amount Due:
*$*_____

**Total Adjustments (attach itemization and/or claims)*
*$*_____

Outlier Period Total Adjusted Amount Due:
*$*_____

TOTAL ADJUSTED AMOUNT DUE FROM THE PLAN: $_____

Hospital*: A separate form must be completed for each transplant. Copies of all claims for the dates of service noted above and included in the Case Rate(s) agreement must be attached. *Total adjustments may include e.g., Payor prior payments for services included in the Case Rate(s) agreement.*

Form Completed by
*(print name)*_____*Phone*_____*Date*_____

Plan Contact
*(print name)*_____*Phone*_____*Date*_____

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ANTHEM CME TRANSPLANT CLAIM BILLING CONTACTS (as of 03/01/16)

Anthem CME Transplant Claim Billing Guidelines and Claim Submission Requirements
Please refer to the Anthem Blue Cross Hospital Provider Manual for billing instructions for non-transplant related claims.

To process your transplant case, please send your CME covered Bundled Hard Copy Transplant Claims and a copy of Form C or D to:

California

Submit all Global Claims except FEP to:
Anthem Blue Cross
Attention Mailroom Supervisor
21555 Oxnard Street
Woodland Hills, CA 91367-4999

FEP Physician Claims

Sandra Holm
FEP Claims Supervisor
Blue Shield of California
4700 Bechelli Lane
Redding, CA 96002

FEP California

Submit FEP Global Claims to:
Anthem Blue Cross
5250 South Virginia Street
Mail Stop NV0101-0115
Reno, NV 89502
Attention: Sabrina Ausum
513.872.3853
Sabrina.Ausum@Anthem.com

Colorado, Nevada

Submit all Global Claims except FEP to:
Anthem Blue Cross
Attention Mailroom Supervisor
21555 Oxnard Street
Woodland Hills, CA 91367-4999

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FEP Colorado, Nevada

Submit FEP Global Claims to:
Mallory Hernandez
Anthem Blue Cross
220 Virginia Ave
Mail Stop IN0204-B576
Indianapolis, IN 46204
317.287.2169
Fax: 317.287.2324
E-mail: Mallory.Hernandez@anthem.com

Connecticut, Maine, New Hampshire

Submit all Global Claims except FEP to:
Maria Johns
Anthem Blue Cross of Connecticut
Prepayment Review-High Dollar Claim Dept.
108 Leigus Road
Mail Stop: CT112D-4083
Wallingford, CT 06492
203.691.6023
Fax: 203.287.9119
E-mail: maria.johns@anthem.com

FEP Connecticut, Maine, New Hampshire

Submit FEP Global Claims to:
Angela Newcomb
Anthem Blue Cross
602 S. Jefferson Street
Roanoke, VA 24011
540.853. 3436
Fax: 540.853. 5133
E-mail: Angela.Newcomb@anthem.com

Georgia

Submit all Global Claims including FEP to:
Lacy Long
Blue Cross and Blue Shield of Georgia
6087 Technology Parkway
Mail Drop: GA082E-0003
Midland, GA 31820
706-985-2347
E-mail: Lacy.Long@Anthem.com

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Indiana, Kentucky, Ohio, Missouri, Wisconsin

Submit all Global Claims except FEP to:
Susan Castner
Anthem Blue Cross
4241 Irwin Simpson Rd
Transplant Unit - Mail Stop OH0203-700
Mason, OH 45040
513.336.4799
Fax: 513.336.5508
E-mail: Susan.Castner@anthem.com

FEP Missouri HMO

Submit FEP Global Claims to:
Susan Castner
Anthem Blue Cross
4241 Irwin Simpson Rd
Transplant Unit - Mail Stop OH0203-700
Mason, OH 45040
513.336.4799 Fax: 513.336.5508
E-mail: Susan.Castner@anthem.com

FEP Indiana (all claims), Kentucky (all claims), Ohio (all claims), Wisconsin (all claims), Missouri FEP PPO

Submit FEP Global Claims to:
Danielle Robbins
Anthem Blue Cross
1099 N. Meridian**, Mail Loc: IN040-M001**
Indianapolis, IN 46204
317.287.2145
Fax: 317.287.2324
E-mail: Danielle.robbins@anthem.com

New York (Empire)

National Accounts:
Submit all Global Claims to:
Brenda Magsamen
Anthem Blue Cross
85 Crystal Run Road | Middletown, NY 10940
845.695.3355
E-mail: brenda.magsamen@anthem.com

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New York (Empire)

Commercial & NYSSC Accounts:
Submit all Global Claims to:
Terri Osborne
Empire Blue Cross and Blue Shield
11 Corporate Woods Blvd. **Mail Stop NY0R4K-9999**
Albany, NY 12211
518.367.5083
Fax: 518.367.6013
E-Mail: terri.osborne@anthem.com

FEP New York (Empire)

Submit FEP Global Claims to:
Stacey Davis
Empire Blue Cross and Blue Shield
11 Corporate Woods Blvd. **Mail Loc: NY0R4Y-0035**
Albany, NY 12211
518.367.4461
Fax: 518.367.6124
E-mail: Stacey.Davis@empireblue.com

Virginia

Submit all Global Claims to:
Renee Gilbert
Anthem Blue Cross of Virginia
2221 Edward Holland Drive
Richmond, Virginia 23230
Mail drop: VA 4004-RR14
919.477.3691
Fax: 919.477.3691
E-mail: renee.gilbert@anthem.com

FEP Virginia

Submit all FEP Global Claims to:
Renee Gilbert
Anthem Blue Cross of Virginia
2221 Edward Holland Drive
Richmond, Virginia 23230
Mail drop: VA 4004-RR14
919.477.3691
Fax: 919.477.3691
E-mail: renee.gilbert@anthem.com

Questions Regarding Claim Payment:
Please refer to the member's identification card or to the section in the _____ Hospital Provider Manual on claim payment

Important:
Please call customer service or the transplant case manager for specific information regarding the member's transplant benefit as described in the Covered Individual's Health Benefit Plan.

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APPENDIX A
COVERED TRANSPLANT SERVICES COVERED BY THIS AGREEMENT

For: _____

Effective: _____

Transplant Type	Adult/Pediatric
Autologous Bone Marrow/ Stem Cell (Single)	
Tandem Autologous Stem Cell First Procedure	
Tandem Autologous Stem Cell Second Procedure	
Allogeneic Bone Marrow/ Stem Cell Related	
Allogeneic Bone Marrow/ Stem Cell Unrelated	
Cord Blood	
Tandem Allogeneic First Procedure (Auto/Allo) (Allo/Allo)	
Tandem Allogeneic Second Procedure (Auto/Allo) (Allo/Allo)	
Heart	
Lung (Single)	
Lung (Double)	
Liver – Deceased Donor	
Liver – Living Donor	
Liver Kidney	
Kidney – Deceased Donor	
Kidney – Living Donor	
Kidney-Pancreas (SPK)	
Pancreas after Kidney (PAK)	
Pancreas (PAT)	

C = Covered by this Agreement
NC = Not Covered by this Agreement

NATIONAL PROVIDER IDENTIFIER (NPI):

HOSPITALTAX IDENTIFICATION NUMBER (TIN):

MEDICAL GROUP TAX IDENTIFICATION NUMBER (TIN):

CMS IDENTIFICATION NUMBER :

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APPENDIX B

Compensation Schedule

Provider Attach Contract Reimbursement Schedule Here

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Published by: netc NETWORK EDUCATION TRAINING COMMUNICATION

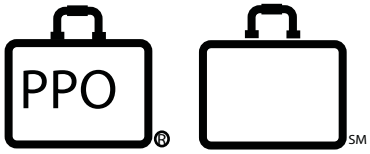
BlueCard® (Out-of-Area)

Anthem Blue Cross participates in the Blue Cross Blue Shield Association (BCBSA) BlueCard® program, which consists of policies and procedures that enable members to receive healthcare services while traveling or living in another Blue Plan's service area.

How does this process work?

Provider

Sends claim to Anthem Blue Cross



Anthem Blue Cross (Host Plan)

- applies pricing
- electronically submits claim to member's plan
- answers all provider claim inquiries

Member's Plan (Home Plan)

- verifies eligibility & benefits
- authorizes Anthem Blue Cross to finalize claim
- forwards electronic submission to Anthem Blue Cross
- sends EOB to member
- answers all member inquiries

Anthem Blue Cross (Host Plan)

- receives electronic disposition
- sends Explanation of Payment (EOP) to provider
- pays provider

$ Provider $

Submit all BlueCard® (out-of-area) claims to Anthem Blue Cross

If submitting by paper, mail to:

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

ID Cards:

- The three alpha characters in front of the member's ID are critical in determining if the claim belongs to another Blue Plan. Include these alpha characters with the member's ID when submitting claims.
- If no group number is indicated on the ID card, insert 999999 when submitting claims.

Anthem Blue Cross Responsibilities:

- Price the claim and forward it electronically to the member's Blue Plan.
- Pay the provider using the Anthem Blue Cross fee schedule and payment method.
- Answer all provider inquiries.

Provider Responsibilities:

- For each service, obtain a copy of the front and back of the current ID.
- Use the Availity Web Portal for eligibility, benefits, and claim status. Use www.anthem.com/ca for Medical Policy, Clinical UM Guidelines, and Pre-Certification Requirements.
- Verify eligibility and benefits by calling **800-676-2583**.
- For medical records, claim inquiries or appeals, call **800-444-2726.**

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BlueCard® (Out-of-Area)

Ancillary Claims Filing:

Ancillary providers include Independent Clinical Laboratory, Durable/Home Medical Equipment and Supplies and Specialty Pharmacy providers. File claims for these providers as follows:

- Independent Clinical Laboratory (Lab)
  The Plan in whose state the specimen was drawn based on the location of the referring provider.
- Durable/Home Medical Equipment and Supplies (D/HME)
  The Plan in whose state the equipment was shipped to or purchased at a retail store.
- Specialty Pharmacy
  The Plan in whose state the Ordering Physician is located.

If you contract with more than one Plan in a state for the same product type (i.e., PPO or Traditional), you may file with either Plan.

Availity Web Portal: Out-of-area member eligibility, benefits, and claims detail is available on the Availity Web Portal with the member's ID number. The alpha prefix must be included. BlueCard Claims Advisor on ProviderAccess® will validate where to send the claim by alpha prefix.

Customer Service:
- Eligibility and Benefits: 800-676-2583
- Claims: 800-444-2726

BlueCard / National Customer Service Escalation Contact List:

You must start your inquiry with the Availity Web Portal and/or Providider Care.

The contacts listed below are to be used as escalation points only if you have exhausted your resources through the Availity Web Portal and Customer Service without resolution. Please have ready any tracking numbers from your conversations with customer service.

Sabina Koehler	Manager, Provider Customer Service	614-438-3481 sabina.koehler@anthem.com
Shirley Pinkney	Operations Expert, West Host Written Correspondence, Availity Secure Messaging	720-364-0005 shirley.pinkney@anthem.com
Howard Dolt	Manager, West Host Written Correspondence, Availity Secure Messaging	303-831-3324 howard.dolt@anthem.com

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Continuity of Care/Transition of Care Request Form

GENERAL INFORMATION ABOUT THE TRANSITION ASSISTANCE PROGRAM

Purpose of Continuity/Transition of Care
The Transition Assistance Program provides a process that allows continued care for members when:

- Their Primary Medical Group (PMG), Independent Physician Association (IPA), Preferred Provider Organization Provider (PPO Provider), Hospital, or other provider is terminated from the Anthem Blue Cross participating provider network.
- They are a new enrollee to Anthem Blue Cross (except members with an Individual contract) and their treating provider is not part of the Anthem Blue Cross participating provider network.
- Continuity of care is at risk for reasons over which the member has no control. (Members who have **elected** to make changes in their coverage which cause them to be out-of-network are not eligible for this program).

Please Note: If you require ongoing care for any chronic condition and you are not in an acute phase of your illness, one requiring a special course of treatment, you should select an in-network provider to meet your ongoing health care needs and you do not need to complete this form. If you need assistance selecting a new provider you should contact Anthem Blue Cross Member Services.

Completing the Continuity/Transition of Care Request Form
You may request Continuity/Transition of Care:

- If you are in an active course of treatment for an acute medical condition or a serious chronic condition. **An acute medical condition** is a medical condition that involves a sudden onset of symptoms due to an illness, injury or other medical problem that requires prompt medical attention and that has a limited duration. **A serious chronic condition** is a medical condition due to a disease, illness, or other medical problem that is serious in nature and that persists without full cure or worsens over time or one that requires ongoing treatment to maintain remission or prevent deterioration. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you are in an active course of treatment for any behavioral health condition;
- If you are pregnant, regardless of trimester;
- If you have a terminal illness;
- If you have a newborn child between the ages of birth and 36 months. Completion of covered services may be provided for a period of time necessary to complete a course of treatment and to arrange for a safe transfer to another provider;
- If you have a surgery or other procedure that has been authorized by the previous plan or its delegated provider and is scheduled to occur within 180 days of the effective date of coverage for a newly covered enrollee.

If one or more of the above situations applies to you and you would like to see if you are eligible for the Transition Assistance Program, please:

- Call the Member Services number on the back of your Anthem Blue Cross card or the Member Services number provided to you in open enrollment and they will assist you with completing your request over the phone.
- Or, fax this completed request form to **1-877-214-1781**.

To help ensure that your care is not disrupted, please complete the entire form below. *Only complete this form if you are receiving ongoing care or are scheduled for care.* ***For Medical Care****: If you are changing to a PPO or EPO and your current medical provider is in our network, or if you are changing to an HMO or POS and will stay in your current PMG or IPA, you do not need to complete this form****.*** *If you are in an HMO or POS and your provider is leaving the PMG/IPA, you do not need to complete this form, you need to contact your PMG/IPA and they will assist you with your transition to a contracting provider****.*** ***For Behavioral Health Care****: If you are changing plans and your provider is not in the Anthem network, please complete this form.*

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Continuity of Care/Transition of Care Request Form

Fill out the form completely, and do not leave any blanks. Please use N/A if the information requested does not apply to your situation. Please complete a separate form for each family member who needs to have care transitioned to another provider.

Subscriber's Name: _____ Subscriber's Anthem Blue Cross ID #: _____

Subscriber's Employer: _____ Date Active with Anthem Blue Cross: _____

Patient's Name: _____ Relationship to Subscriber: _____

Date of Birth: _____ Allergies: _____

Preferred Phone #: _____ ☐Home ☐Work ☐Cell Secondary Phone #: _____ ☐Home ☐Work ☐Cell

Name of Terminating Insurance Plan: _____

Circle Type of Terminating Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐ OTHER

New Anthem Blue Cross Plan: ☐HMO ☐Vivity ☐POS ☐PPO ☐EPO ☐CDHP ☐OTHER

Are You a New Enrollee to Anthem Blue Cross: ☐Yes ☐No

Name of PMG/IPA with Terminating Plan: _____ Name of New Anthem Blue Cross PMG/IPA: _____

For Network Disruption (PMG, IPA, PPO Provider, or Hospital has terminated from the Anthem Blue Cross Participating Provider Network) please provide the name of the terminating Hospital or Provider: _____

Diagnosis (include pertinent history and physical findings): _____

_____

1. Do you have an upcoming appointment to see a specialist? ☐Yes ☐No

If yes, please provide the applicable information below.

Specialist Type	Provider Name (last, first)	Provider Phone Number	Date of Office Visit	Reason
Heart Specialist				
Lung Specialist				
Blood or Cancer Specialist				
Neurologist				
Infectious Disease Specialist				
Kidney Specialist				
Behavioral Health Specialist				
Orthopedic Specialist				
Obstetrician for pregnancy Due Date: Hospital for delivery:				
Other: Please be specific _____				

Continuity of Care: Application New Enrollee and Application Network Disruptions consolidated herein. Last revised 05/09/16.

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Anthem Blue Cross

Continuity of Care/Transition of Care Request Form

2. Are you currently receiving any of the following services? ☐Yes ☐No

If yes, please provide the applicable information below.

Services	**Facility or Company, Medical or Behavioral Health Provider**
Clinical Laboratory	
Oxygen	
IV Medication/Chemotherapy	
Physical Therapy	
Radiation Therapy	
Home Therapy	
Rehab Treatment	
Organ or Stem Cell/Bone Marrow Transplant	
Medical Equipment	
Medication Management for a Behavioral Health condition	
Dialysis	

3. Do you have any hospitalizations, surgeries or procedures scheduled? ☐Yes ☐No

Date _____Type of Surgery/Procedure _____

Name/Phone Number of Physician performing surgery/procedure _____

Hospital/Facility _____

4. Have you been admitted to the hospital or seen in the emergency room in the past 6 months? ☐Yes ☐No

Reason _____Hospital _____

Date(s) of Service _____

5. Other Needs _____

I hereby authorize the above provider to give the Anthem Blue Cross Transition Assistance Department and/or Care Management any and all information and medical records necessary to make an informed decision concerning my request for Transition of Care/Continuity of Care. I understand that the Anthem Blue Cross Transition Assistance Department and/or Care Management may share information and discuss my care with my new Primary Care Physician/Medical Group under my Anthem plan. I understand that I am entitled to a copy of this authorization form.
I also authorize Anthem Blue Cross to leave confidential information on my voice mail at the following number(s) listed above. Please check all that apply:
☐ Home ☐ Cell ☐ Work ☐ Do NOT leave confidential information on my voice mail

Signature of Patient if 18 or over: Date:

Signature of Parent or Guardian if Patient is under 18: Date:

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COORDINATION OF CARE FORM

(Please write clearly)

Patient Name _____ Patient Date of Birth _____

Treating Provider Information

Name: _____ Phone: _____

Address: _____ Fax: _____

The patient is being treated for the following problems:

- ☐ Mental Health Diagnosis
- ☐ Medication Management
- ☐ Substance Abuse
- ☐ Eating Disorder
- ☐ Other Mental Health Issues _____
- ☐ Chronic Illness
- ☐ Routine Care
- ☐ Change in Medical Status

Treatment Start Date _____ Date of Last Appointment _____

Expected Next Appointment _____

Medication and Dosages

1:

2:

3:

4:

Significant information that may impact medical or behavioral health including hospitalizations and description of chronic medical illness:

**If you would like to discuss this patient's treatment, please contact me at the number above.*

_____ _____

Practitioner Signature Date

Coordination of Care Letter

PCP/Other Practitioner First Name/Last Name/Title

City, State ZIP

Re: Member Name: Member Name

Member DOB: Member DOB

Dear Recipient:

I am writing to let you know that I saw your Member named above for a mental health assessment on Date of Visit_____. The Member reported symptoms that I believe are consistent with the diagnosis of _____. I have recommended the following:

Recommendation

This Member has signed an authorization form, allowing us to exchange pertinent information with you. If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

Respectfully,

Clinician Name/Degree/Licensure

Clinician Title

cc: File Copy to Member Medical Record

Coordination of Care Letter

Practitioner First Name/Last Name/Title

City, State ZIP

Re: Member Name: Member Name

Member DOB: Member DOB

Dear Recipient:

I am writing to let you know that I saw your Member named above for a medical office visit on Date of Visit _____. The Member reported symptoms that I believe are consistent with the diagnosis of _____. I have recommended the following:

Recommendation

This Member has signed an authorization form, allowing us to exchange pertinent information with you. If you would like any further contact regarding this case, or if you have further information that you think might assist us in better meeting this individual's clinical needs, please feel free to contact me directly.

Respectfully,

Practitioner Name

Degree/Licensure

cc: File Copy to Member Medical Record

Facility Electronic Census Reporting File Feed Requirements

Anthem Blue Cross Contacts:

Kurt Baumgartner
Business Consultant
(805) 713-3856
Kurt.Baumgartner@Anthem.com

Neil Morales
Business Consultant
(805) 713-4607
Neil.Morales@Anthem.com

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Introduction

1.1 Purpose

To describe the process of establishing census reporting from a partnering facility

1.2 Target Audience

Acute facilities wanting to electronically submit their daily census files to a secure Anthem Blue Cross server

1.3 Definitions, Acronyms, and Abbreviations

WMDS	Wellpoint Medical Management System
FTP	File Transfer Protocol

1. Business Requirements

- File should include ***only*** patients with Anthem Blue Cross Commercial (HMO and PPO), Senior CA Business, State Sponsored Business, and Federal Employees coverage that occupy an inpatient (medical) bed at the time of file creation (a midnight census).
- **Out of Scope**:
  Out of State Blue Cross members

Technical Requirements

File Naming: Production---→ Test File --→	 CensusFeed<FacilityName>_<yyyymmdd>.txt. TestCensusFeed<FacilityName>_<yyyymmdd>.txt
Format:	Text delimited file with a delimiter '~'
Testing:	Please submit a test file via FTP with the appropriate File naming Convention. The file will be reviewed and tested in the system for compliance with format and content
Data Transmission:	FTP to WellPoint, Inc WellPoint's FTP group will forward the FTP Server IP address and the ID/Password to the Facilities IT contact
Security:	The file must be PGP encrypted. If it is not encrypted, the

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	WellPoint processes is unable to recognize the file
Transmission Schedule:	Daily Timed between – 12:00AM and 7:00AM PST **Note**: Files transmitted are processed by Anthem Blue Cross Monday through Friday, excluding holidays. Files transmitted on holidays, Saturdays, or Sundays will be processed on Monday or the next business day

4. Daily Census Feed File Layout

Field Name	Field Description	Format Type	Format	Length	Characteristics
Facility Name	**Hospital Name**	Alphanumeric		50	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Provider Number (Legacy Medicare ID)	Hospital's Legacy Medicare ID number	Alphanumeric		15	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Member ID	Patient's Anthem Blue Cross ID/policy number	Alphanumeric		15	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Patient's Last Name	Last name of patient	Alphanumeric		30	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Patient's First Name	First name of patient	Alphanumeric		30	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Date of Birth	Patient's Date of Birth	Date	mm/dd/yyyy	10	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Sex	Male or Female	Alphanumeric		6	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Anthem Ref#	Reference number is provided by Anthem Blue Cross Utilization Management	Alphanumeric		20	No Data Please
~	***Field separator***	~		***1***	***Mandatory***
HMO Auth	Authorization code/number provided by	Alphanumeric		30	No Data Please

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	PMG				
~	***Field separator***	~		***1***	***Mandatory***
Admit Date	Date patient was admitted	Date	mm/dd/yyyy	10	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Discharge Date	Date patient was discharged. ****Note**: This field is for Anthem Blue Cross use only. Facility file will always have this field as blank	Date	mm/dd/yyyy	10	Optional
~	***Field separator***	~		***1***	***Mandatory***
Attending MD	Name of Attending Physician	Alphanumeric		30	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Admitting MD	Name of Admitting Physician	Alphanumeric		30	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Primary DX	Description of Admitting Diagnosis /Reason for Admission	Alphanumeric		30	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
CPT code	**NOTE:** Field can be used by the facility for Patient account number as this is not used by Anthem Blue cross for any type of validation	Alphanumeric		15	Optional
~	***Field separator***	~		***1***	***Mandatory***
Hospital Service	Level of Care (LOC)	Alphanumeric		50	Optional
~	***Field separator***	~		***1***	***Mandatory***
Submittal Date	Date census report is sent to Anthem Blue Cross	Date	mm/dd/yyyy	10	Mandatory
~	***Field separator***	~		***1***	***Mandatory***
Submittal Time	Time census Report is sent to Anthem Blue Cross	Alphanumeric	HH:MM	10	Mandatory
Provider Number (TAX ID)	Hospital's Tax ID (9-Digit)	Alphanumeric		9	Optional
~	***Field separator***	~		***1***	***Mandatory***

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Patient Telephone Number	Patient's phone number	Alphanumeric	(xxx) xxx-xxxx	30	Optional
~	***Field separator***	~		***1***	***Mandatory***
Admit Time	Time patient was admitted	Time	HH:MM AM/PM	10	Optional
~	***Field separator***	~		***1***	***Mandatory***
Attending MD Provider ID	Attending Physicians Tax ID	Alphanumeric		*10*	Optional
~	***Field separator***	~		***1***	***Mandatory***
Attending MD Provider ID	Attending Physicians NPI ID	Alphanumeric		*10*	Optional
~	***Field separator***	~		***1***	***Mandatory***
Attending MD Address	Provide street address, city, state, and zip code	Alpha Numeric		50	Optional
~	***Field separator***	~		***1***	***Mandatory***
Classification of Service	Description of the classification of service (e.g. Emergency, Urgent, Elective)	Alphanumeric		10	Optional
~	***Field separator***	~		***1***	***Mandatory***
Admitting DX Code	Provide Diagnosis Code	Alphanumeric	xxx.xx	10	Optional
~	***Field separator***	~		***1***	***Mandatory***
UM Dept Telephone Number	Facility POC contact #	Alphanumeric	(xxx) xxx-xxxx	30	Optional

**** Note: No header required on the text file****

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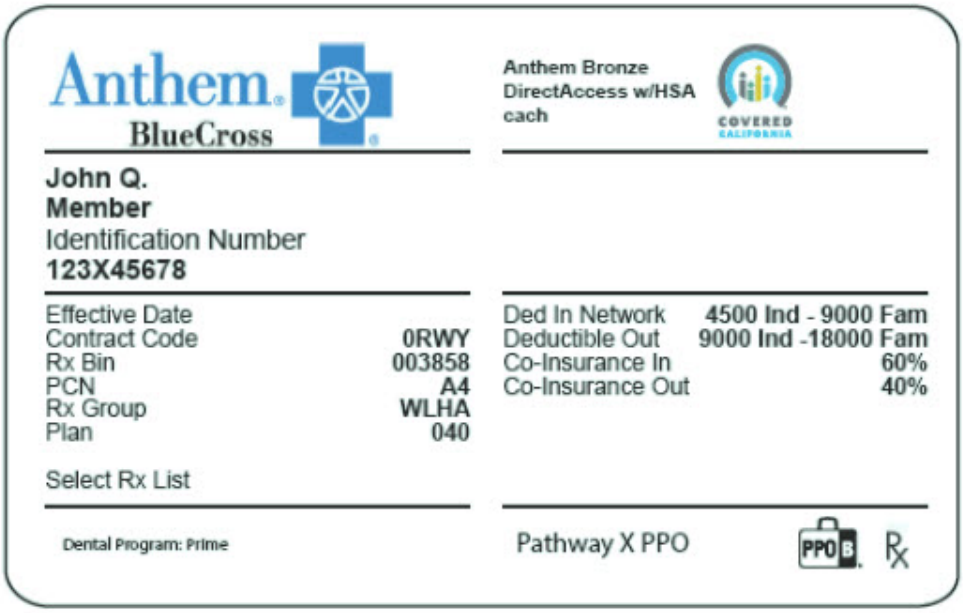
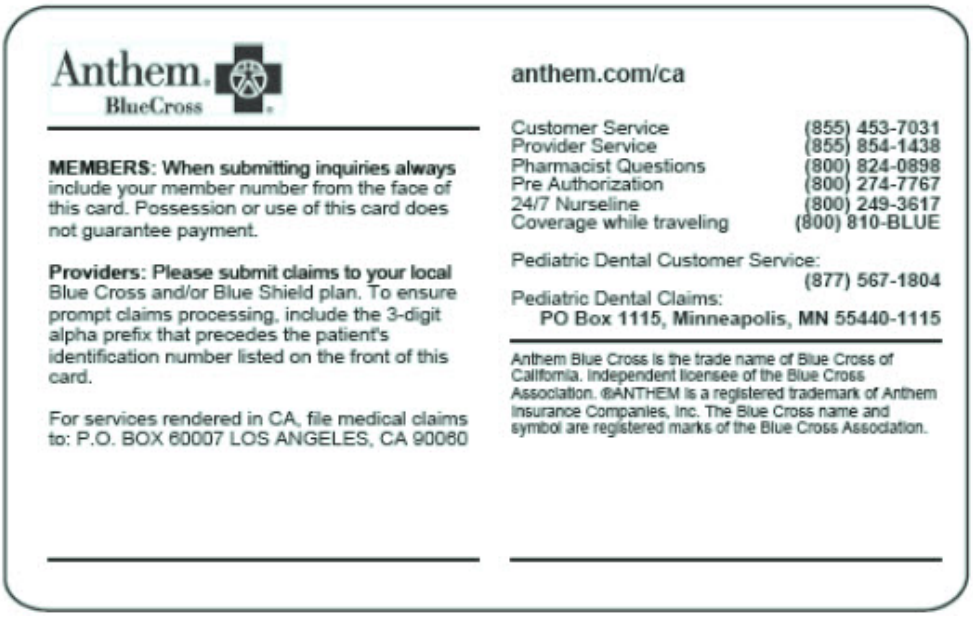
Anthem Blue Cross Health Insurance Exchange ID Card

Sample: Front

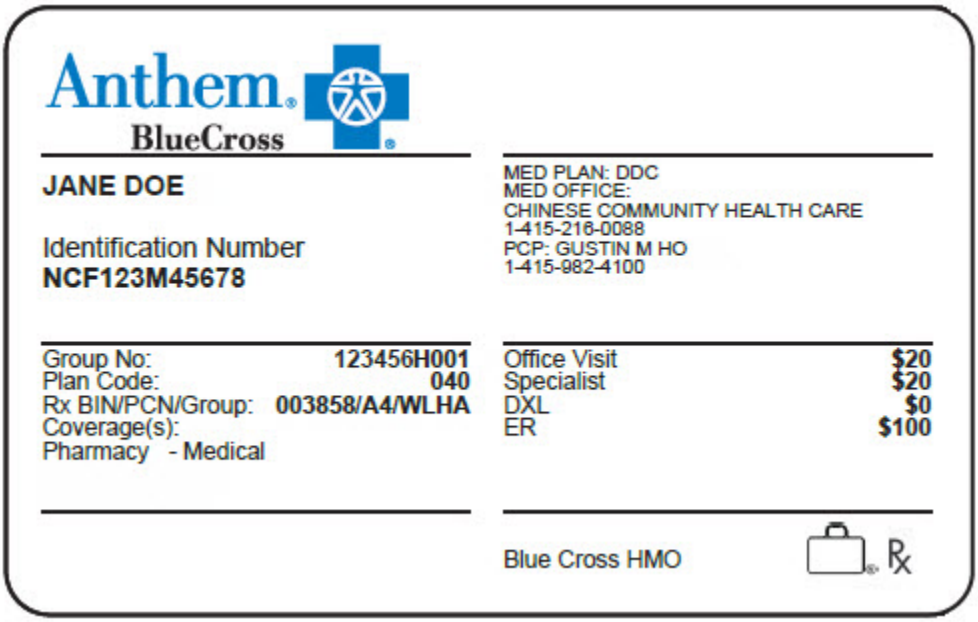


Sample: Back

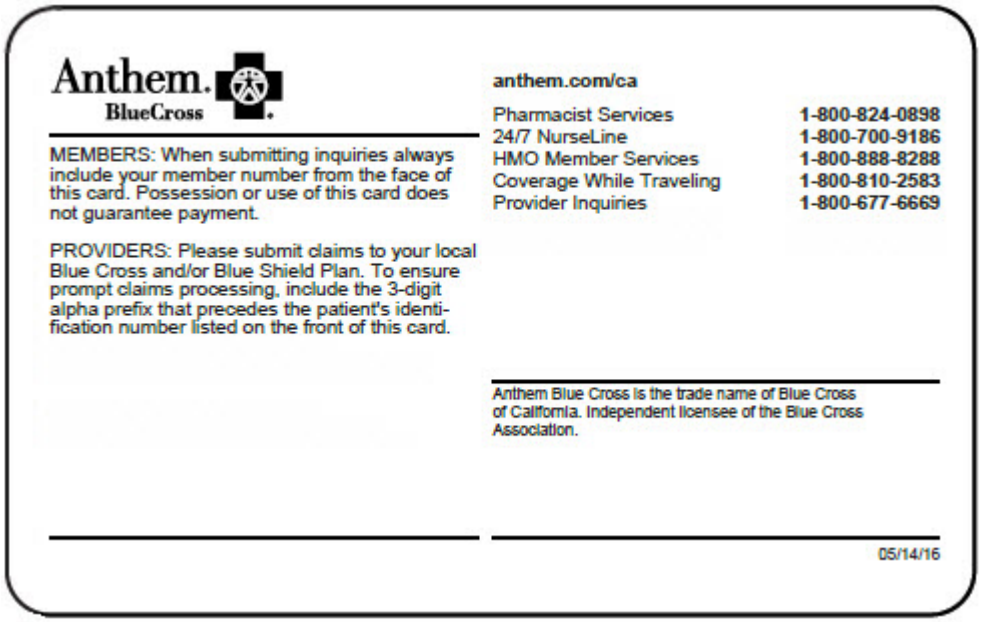


Anthem Blue Cross HMO ID Card

Sample: Front

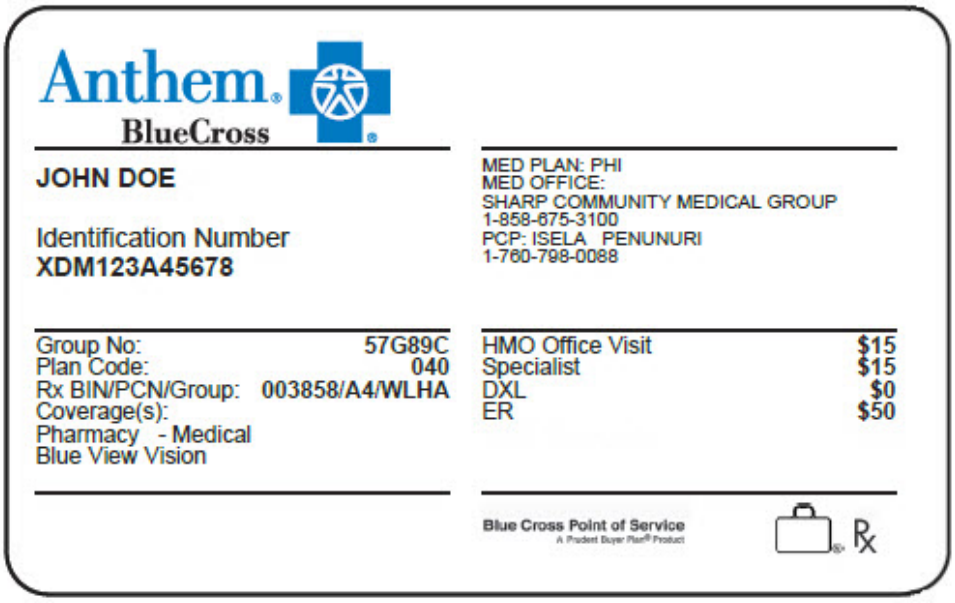


Sample: Back

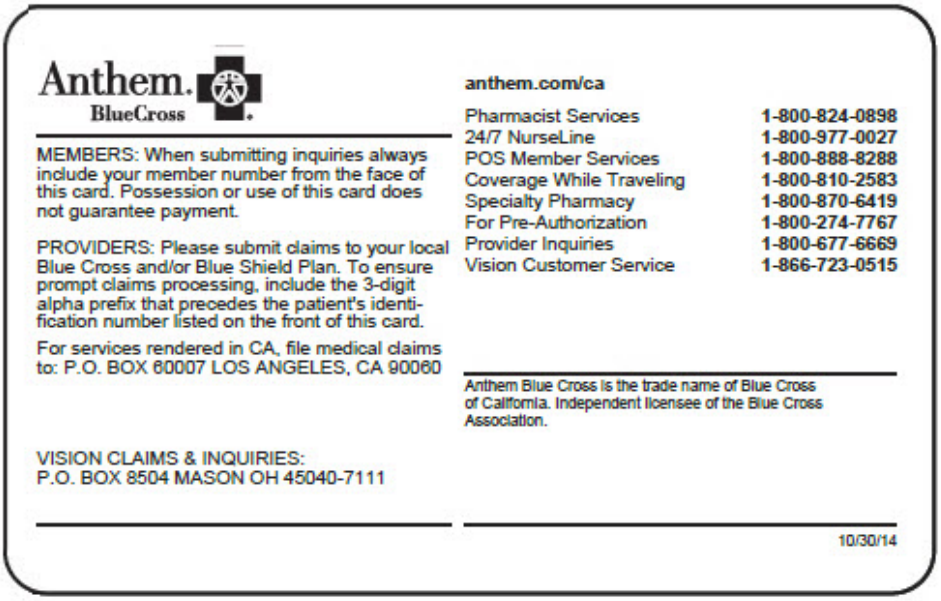


Anthem Blue Cross POS ID Card

Sample: Front

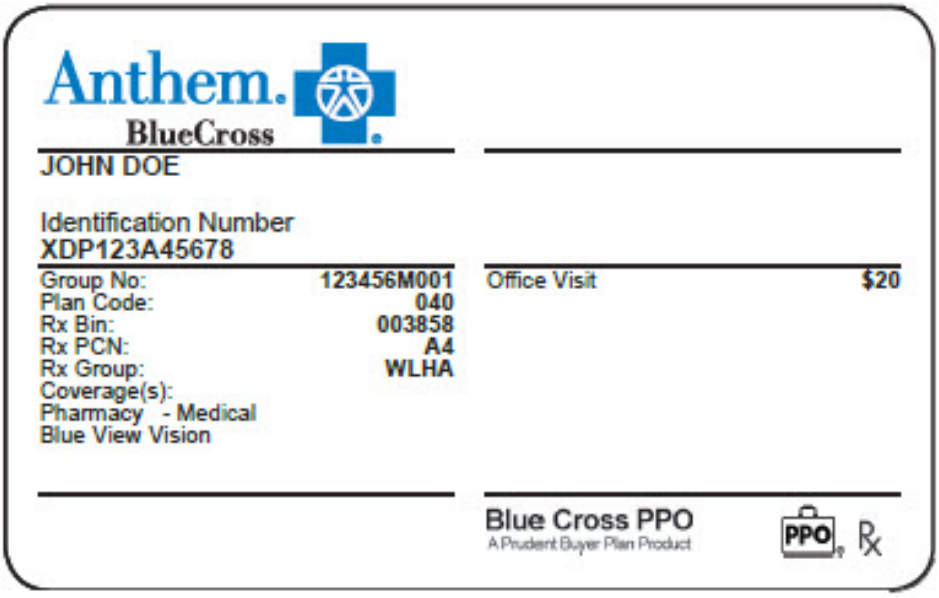


Sample: Back



Anthem Blue Cross PPO ID Card

Sample: Front



Sample: Back

Facility Binding Independent Review Organization(IRO) Request

Note* Submission of this form constitutes Facility's agreement to assume financial cost of IRO in accordance with terms of your Facility Agreement with Anthem. Unless stated otherwise in your agreement, IRO costs shall be equally divided between Facility and Anthem for each claim reviewed.

INSTRUCTIONS

- Please fill out this form as completely as possible.
- The Provider must have completed the Anthem Provider Dispute Resolution process for the claim before submitting the claim through this IRO process. Further, this form is to be used for medical necessity disputes only.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute.
- Mail the completed form to:

Anthem Blue Cross
Risk Unit AC-6C
P.O. Box 60007
Los Angeles, CA 90060-0007

*PROVIDER NAME:	*TAX #:
PROVIDER ADDRESS:	

FACILITY TYPE ☐ Mental Health ☐ Acute Hospital ☐ SNF ☐ Acute Rehab

*** CLAIM INFORMATION**

* Patient Name:		Date of Birth:
* Health Plan ID Number:	Patient Account Number:	Original Claim ID Number:
Service "From/To" Date	Original Claim Amount Billed:	Original Claim Amount Paid:

DISPUTE TYPE:	IRO to be used (choose one only)
☐ Level of Care (LOC)	☐ AMR
☐ Length of Stay (LOS)	☐ MCMC
☐ Experimental/Investigational	☐ AllMed

DESCRIPTION OF DISPUTE AND EXPECTED OUTCOME:

Contact Name (please print)	Title	( ) Phone Number
Signature	Date	( ) Fax Number

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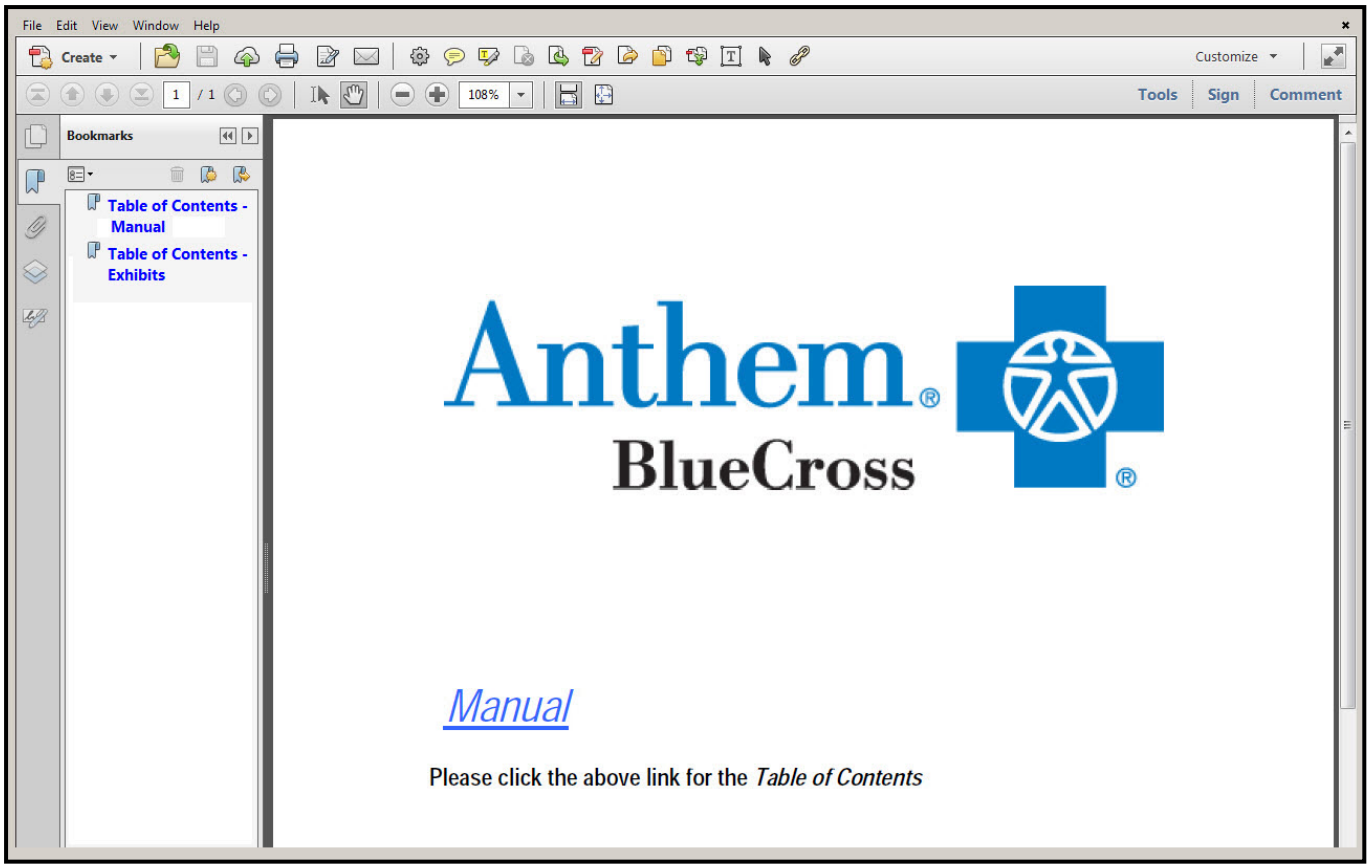
Using the Search Tool (CD-ROM Version)

Anthem Blue Cross has created this step-by-step guide for searching specific items or key words throughout Anthem Blue Cross manuals. The search tool is a function of Adobe Acrobat, the file format used for our manuals.

Note:

- Search key words when viewing the entire manual on a CD-ROM.
- Search keyword by section only in ProviderAccess®

STEP 1: Insert the Anthem Blue Cross Manual CD-ROM into your CD-ROM drive and open any of the Adobe Acrobat files. In most cases, the CD-ROM loads automatically, and the title page displays.



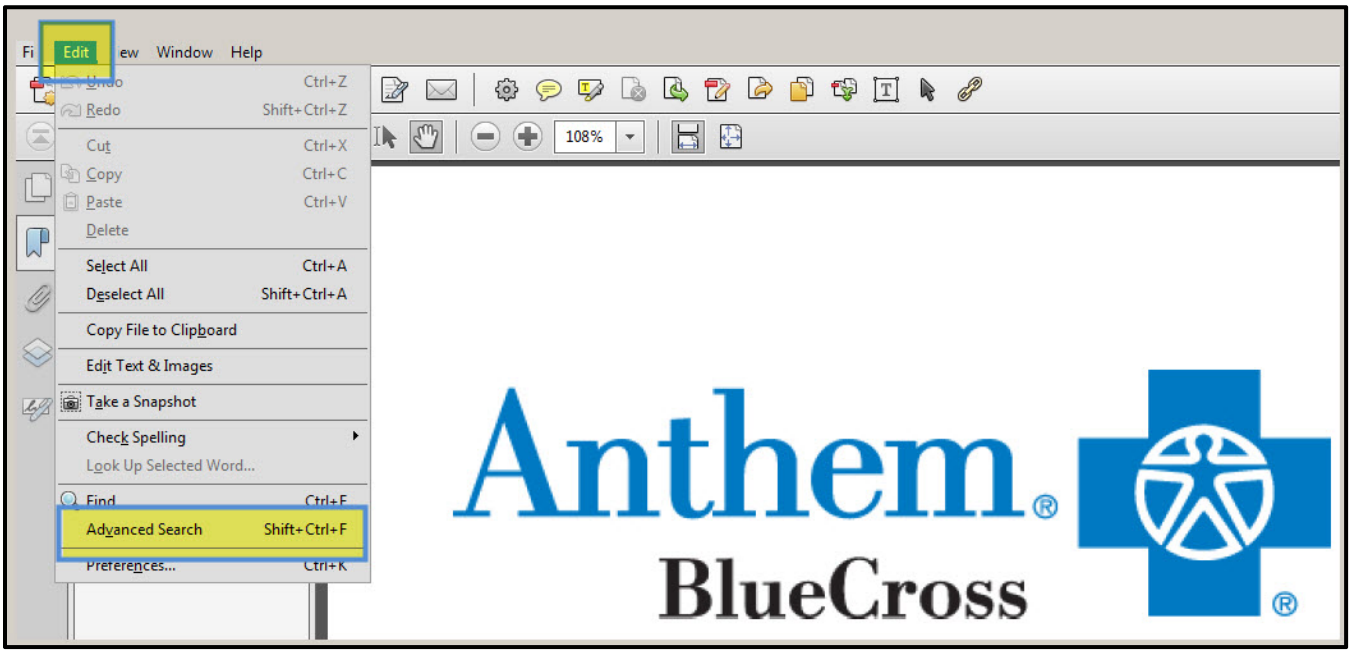
If it doesn't, follow the instructions located on the back of the CD-ROM jacket to open:

1. Insert the CD in your CD-ROM drive.
2. The CD should automatically load and open an Acrobat (.pdf) file with a **title page**. Click on the title of the manual to open the Table of Contents.
3. If the file does not open, go to My Computer and click on the CD-ROM drive.
4. Open the file **title**.

If you do not have Acrobat Reader installed on your computer, follow these steps:

1. Go to **My Computer** and select the CD-ROM drive, and open the folder named **Acrobat.**
2. Copy the file named **Acrobat Reader Program file** to your desktop.
3. Click on this file and it will install Acrobat Reader on your computer.

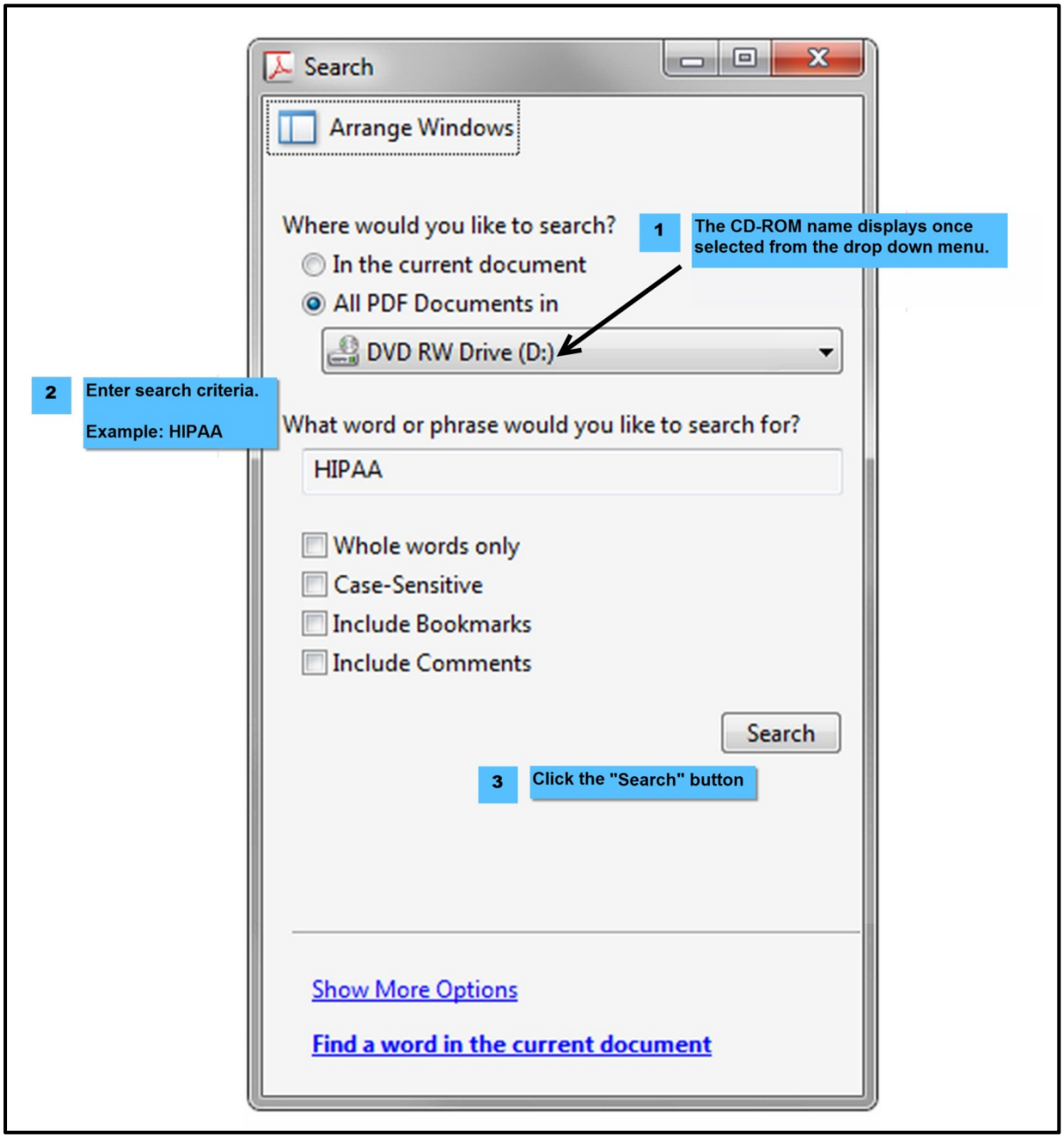
STEP 2: At the top of the page, select the "Edit" tab then the menu option, "Advanced Search".



STEP 3: Search window appears. Enter criteria then click the “Search” button”.

Question 1 **“Where would you like to search?”** Below that question, you have two options. Click the second option, “All PDF documents in,” and use the drop down menu to select the CD-ROM. In this example, the letter of the drive (D) displays. The drive letter varies, depending on your computer mapping.

Question 2 **“What word or phrase would you like to search for?”** appears above a free form text box. Enter search criteria, the key word(s) you want to find in the Manual. In this example, “HIPAA” Is entered here.

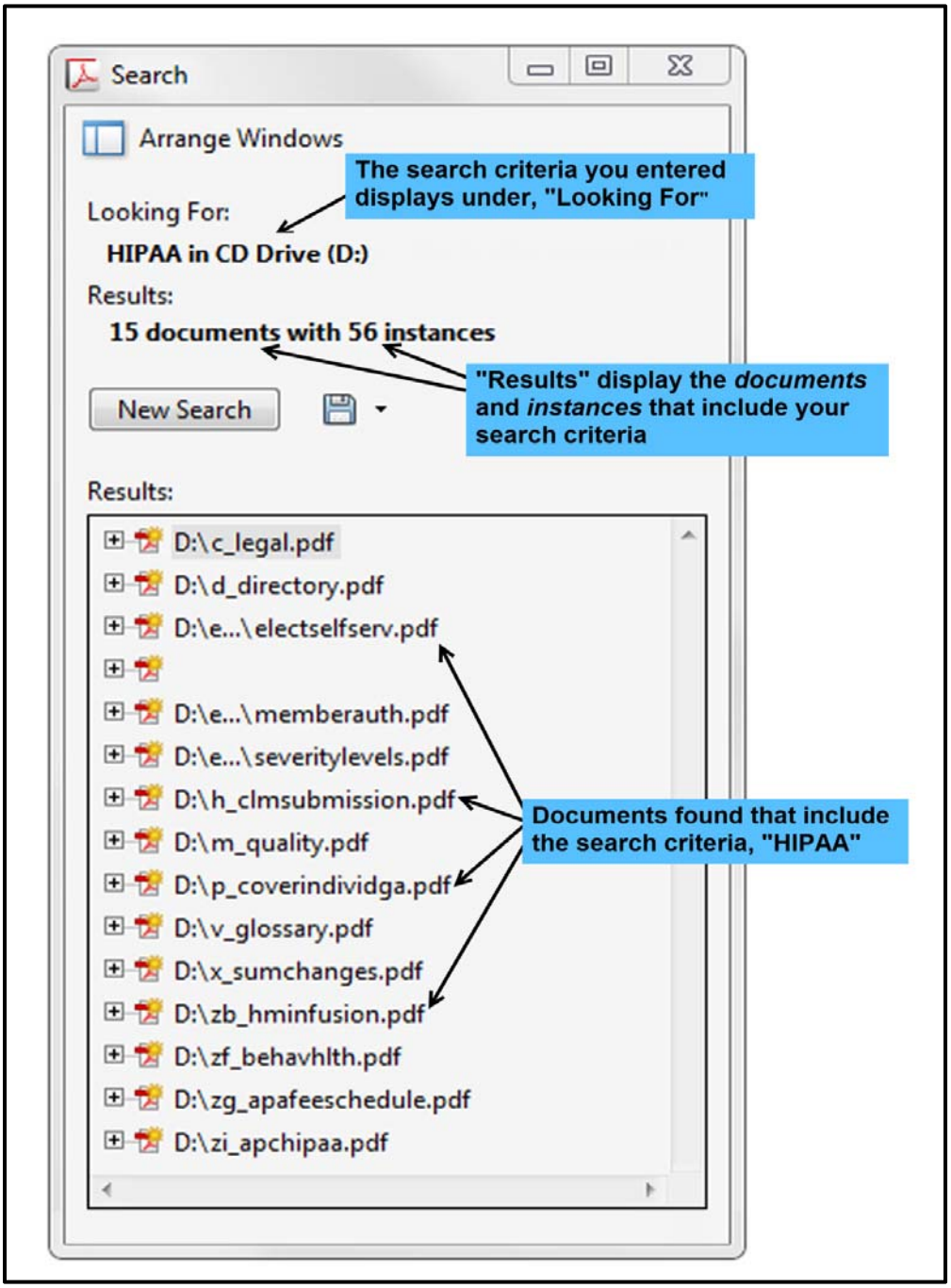


STEP 4: The details of your search display in the window. A sample of of search results displays below.

A document list, where the word(s) appear throughout the Manual, display in the box labeled “Results”. Click on the “+” to the left of the listing to find the “instance”, the exact location of the search word(s).

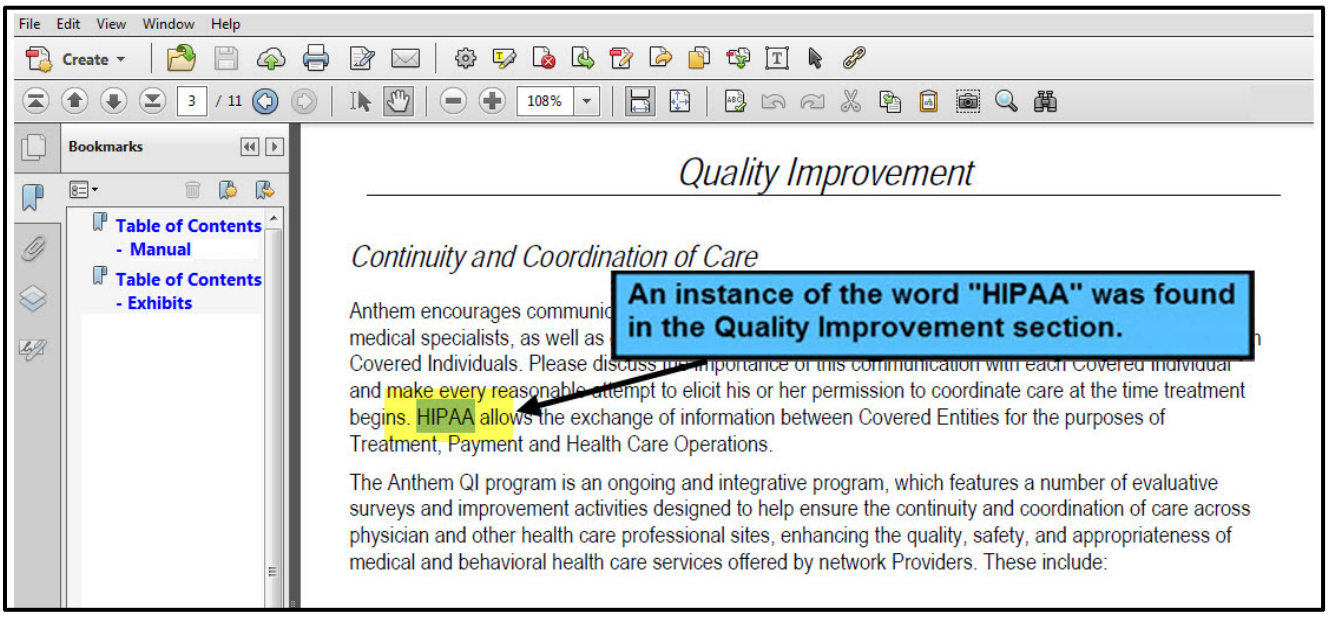
That document or instance is a link which takes you directly to that location in the Manual.

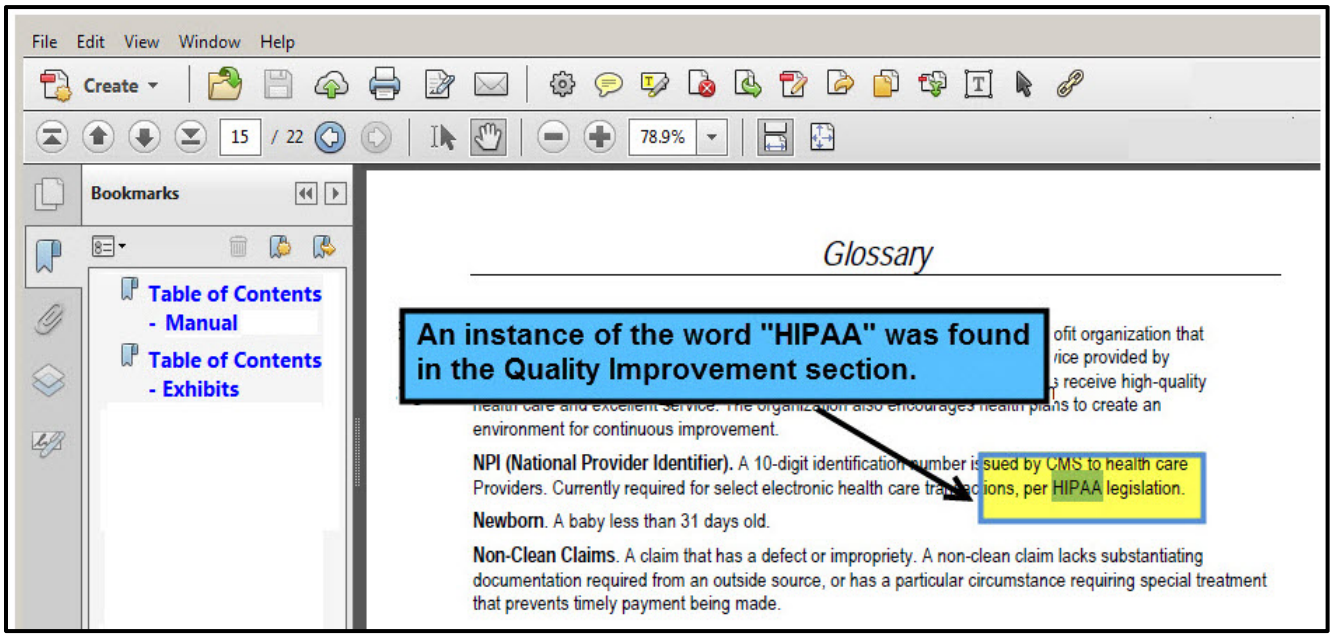
SAMPLE



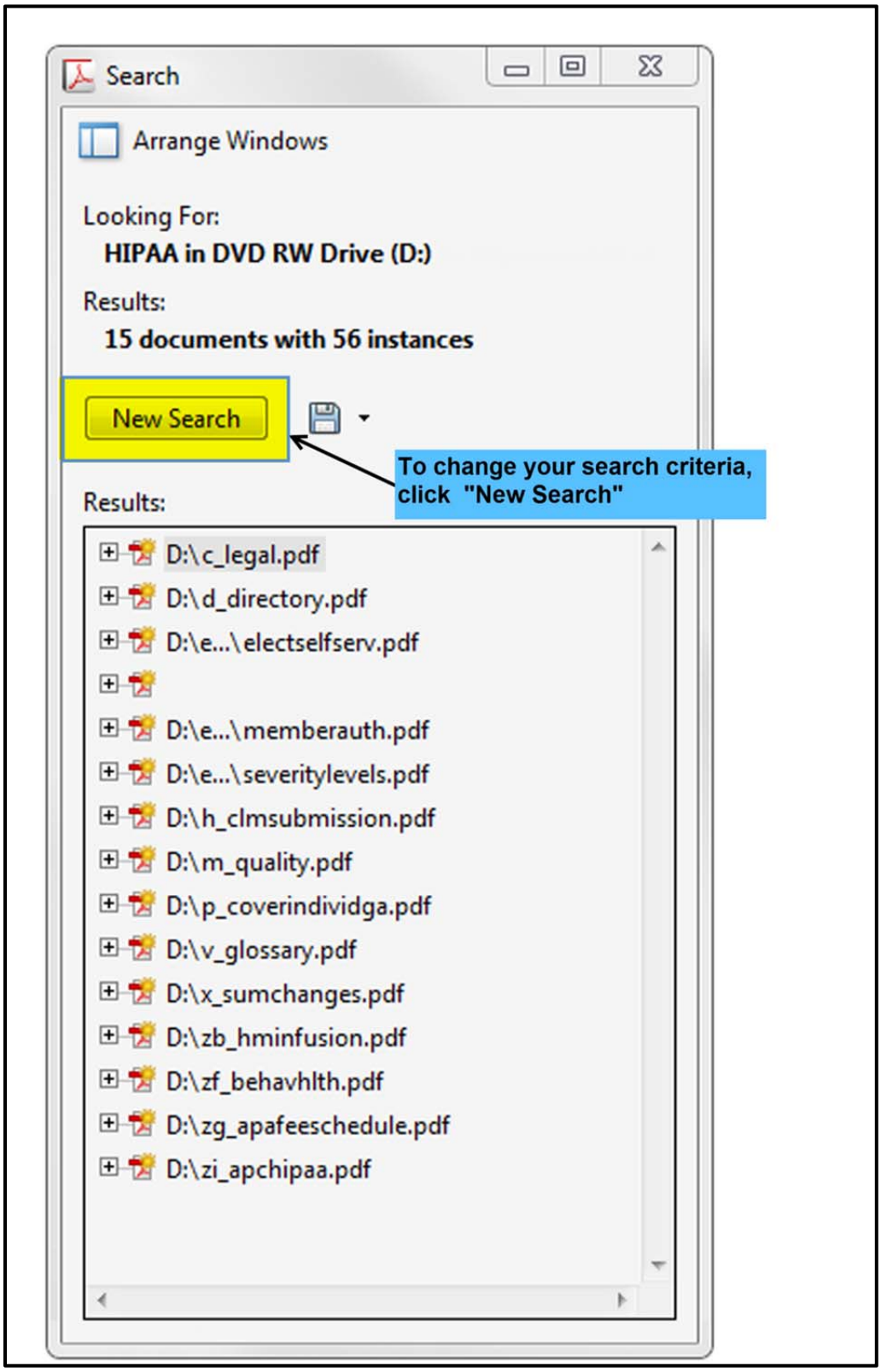
Step 7: Click a document or instance in the "Results" box and you are taken directly to the location of that occurrence.

When you are finished reviewing that occurrence, simply click on another document or instance to be linked to the other locations in the Manual where the search word(s) can be found.





STEP 8: To conduct a different search, click on the "New Search" button.



ANTHEM BLUE CROSS

MEMBER (PATIENT) RESPONSIBILITY AGREEMENT – WAIVER FORM

Contracting Anthem Blue Cross health care professionals/facilities ("Providers") are prohibited from charging Anthem Blue Cross Members for any service or supply that is determined by Anthem Blue Cross to be not Medically Necessary or non-covered, unless the Members specifically agrees in advance of the provision of the service or supply to be financially responsible for such service or supply. This waiver form, or another writing documenting the contents of this form and executed in accordance with the timeframe contained herein, shall be used by the Provider to document the Member's agreement to be responsible for such service or supply. In such instances this form or such other writing must be separate from any patient payment responsibility information in the hospital admission form. To be effective and valid, this waiver form must be executed prior to the delivery of any non-Medically Necessary or non-covered service or supply.

MEMBER (PATIENT) NAME:_____ DOB:_____

SUBSCRIBER ID:_____GROUP NO.:_____

PROVIDER: _____

PROVIDER NPI/TAXID: _____

PROVIDER PHONE: _____

MEMBER:

By signing below, I agree to pay Provider for those services or supplies that Anthem Blue Cross determined were not Medically Necessary or otherwise not a covered benefit or excluded under my coverage.

☐ Not Medically Necessary;
☐ Primarily for comfort and convenience; or
☐ Otherwise not a covered benefit or excluded under my coverage

I understand that a contracted Anthem provider may not charge me for a service or supply determined to be not Medically Necessary or non-covered unless I have specifically agreed to pay for it. I also understand that the Provider and/or I may appeal any determination that a service or supply is not Medically Necessary or non-covered by filing a grievance or appeal with Anthem Blue Cross or the Department of Managed Health Care ("DMHC") pursuant to the grievance and appeals procedures described in my Benefit Agreement or Evidence of Coverage ("EOC"). I also understand that I may also have the right to Independent Medical Review through the DMHC, as described in my Benefit Agreement or EOC.

For the services and/or supplies listed below, I understand that I am financially responsible for payment to the Provider, even though they may not be shown on my Explanation of Benefits (EOB) as my financial responsibility.

Date(s) of Service	Description of Service and/or supply	Approximate Cost of service and/or supply	Member's (Patient's) Responsibility

Signature: _____ Date: _____

Member/ Subscriber Signature

PROVIDER:

Provider, please send a completed copy of this waiver form along with the initial claim to the claims address on the Member (Patient's) identification card for appropriate claims processing. This does not represent a renegotiation of an already negotiated rate between Provider and Anthem Blue Cross.

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Instructions for Completing the Member Authorization Form

If you have any questions, please feel free to call us at the customer service number on your member identification card.

Please read the following for help completing page one of the form.

PART A: MEMBER INFORMATION

This section applies to the member who is asking for the release of his or her information to another person or company.

1. Print your last name, first name, and middle initial
2. Write your date of birth in this format: mm/dd/yyyy. (If you were born on October 5, 1960, you would write 10/05/1960.)
3. Write your full street address, city, state, and ZIP code
4. Write your daytime phone number (including area code)
5. **Identification number**
   You will find this number on your member identification card
6. **Group number**
   You will find this number on your member identification card. If your identification card does not have a group number leave this blank.

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

7. Check the box that applies to you. Write the full name of the person or company that you want us to give your information to. Please don't use a general term like "my daughter" or "my son" as it will not be accepted. You need to be specific.
8. If you check "Other," give the first and last name (if available), the name of the company (if applicable), and how they relate to you.

PART C: INFORMATION THAT CAN BE RELEASED

This section tells us what information you would like us to release: all or just some.

9. For "all of your information," check the first box.
10. For "limited information," check the second box and the boxes that apply to you.
11. Some topics may be very personal or sensitive to you. If you wish to approve the release of this type of information, check the box(es) that apply to you.

Member Authorization Form

Anthem BlueCross

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name (1)	Member first name	Middle initial	Member date of birth (2)
Member street address (3)	City	State	ZIP code

Daytime telephone number (with area code) (4)	Identification number (see identification card) (5)	Group number (see identification card) (6)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

- ☐ **My spouse** (enter first and last name) (7)
- ☐ **My parents** (if you are over 18 - enter first and last name[s])
- ☐ **My domestic partner** (enter first and last name)
- ☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
- ☐ **My adult children** (enter first and last name[s])
- ☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you) (8)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Anthem Blue Cross on my behalf (check only one box):

(9) ☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

(10) ☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all boxes that apply to you):

(11) ☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

22940CAMENABC 3/12

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1 of 2

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Please read the following for help completing page two of the form.

PART D: PURPOSE OF THIS APPROVAL

This section tells us the reason you've asked for the release of your information.

1. Check the first box to let us know to give out this information as shown on this form.
2. Check the second box for a specific reason. An example might be to settle a life insurance claim.

PART E: DATE YOUR APPROVAL EXPIRES

You have two choices of when you would like this approval to end.

3. Check the first box for the standard one-year that it will end.
4. Check the second box for an earlier date (other than one year), and give the date you wish this approval to end.

Your authorization/approval can't be granted for more than one year.

PART F: REVIEW AND APPROVAL

5. **Sign your name and put the date on the form.** Your name and signature ***must*** match the information in Part A.
6. **If you are signing this form on behalf of another person, or if you have Power of Attorney for health care, or are a legal guardian/conservator you must do the following:**
   - You must complete the Designated Legal Representative/Guardian section.
   - You must also provide us with a copy of the legal document showing that you are approved and include it with this form.

PART D: PURPOSE OF THIS APPROVAL

1 ☐ To give out the information as shown on this form

OR

2 ☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

3 ☐ One year from the signature date in Part F

OR

4 ☐ Earlier than one year and upon the date, event or condition described below

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Anthem Blue Cross to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Anthem Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem Blue Cross. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature 5	Date
X	

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN 6

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date
X	

Please return the completed form to:
Anthem Blue Cross

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number

Examples of legal documents:

- **Health Care, General or Durable Power of Attorney**. This document gives someone you trust the legal power to act on your behalf and make health care decisions for you.
- **Legal Guardianship**. This is when the court appoints someone to care for another person.
- **Conservatorship**. This happens when a judge appoints a responsible person to make decisions for someone who can't make responsible decisions for him/herself.
- **Executor of estate**. This type of document would be used when the person who is being represented has died.

Member Authorization Form

Anthem BlueCross

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al número de servicio al cliente que aparece al dorso de su tarjeta de identificación o en el folleto de inscripción.

This form is to be filled out by a member if there is a request to release the member's health information to another person or company. Please include as much information as you can.

PART A: MEMBER INFORMATION

Member last name	Member first name	Middle initial	Member date of birth
Member street address	City	State	ZIP code

Daytime telephone number (with area code)	Identification number (see identification card)	Group number (see identification card)

PART B: PERSON OR COMPANY WHO WILL RECEIVE THIS INFORMATION

The following people or companies have the right to receive my information. (They must be 18 years of age or older). Please check each box that applies and enter first and last name.

☐ **My spouse** (enter first and last name)	☐ **My parents** (if you are over 18 - enter first and last name[s])
☐ **My domestic partner** (enter first and last name)	☐ **My insurance broker or agent** (enter the name of the company and first and last name, if you have it)
☐ **My adult children** (enter first and last name[s])	☐ **Other** (enter first and last name [if you have it], name of company, and how it's related to you)

PART C: INFORMATION THAT CAN BE RELEASED

I allow the following information to be used or released by Anthem Blue Cross on my behalf (check only one box):

☐ **All my information**. This can include health, a diagnosis (name of illness or condition), claims, doctors and other health care providers and financial information (like billing and banking). This doesn't include sensitive information (see below) unless it is approved below.

OR

☐ **Only limited information** may be released (check all boxes below that apply to you).

- ☐ Appeal
- ☐ Benefits and coverage
- ☐ Billing
- ☐ Claims and payment
- ☐ Diagnosis (name of illness or condition) and procedure (treatment)
- ☐ Eligibility and enrollment
- ☐ Financial
- ☐ Medical records
- ☐ Doctor and hospital
- ☐ Pre-certification and pre-authorization (for treatment approvals)
- ☐ Referral
- ☐ Treatment
- ☐ Dental
- ☐ Vision
- ☐ Pharmacy
- ☐ Other: _____

I also approve the release of the following types of sensitive information by Anthem Blue Cross (check all boxes that apply to you):

☐ **All sensitive information**

OR

☐ **Just information about topics checked below**

- ☐ Abortion
- ☐ Abuse (sexual/physical/mental)
- ☐ Alcohol/substance abuse **
- ☐ Genetic testing
- ☐ HIV or AIDS
- ☐ Maternity
- ☐ Mental health
- ☐ Sexually transmitted illness
- ☐ Other: _____

** I understand that my alcohol/substance abuse records are protected under Federal and State confidentiality laws and regulations and cannot be disclosed without my written consent unless otherwise provided for in the laws and regulations. I also understand that I may revoke (or cancel) this approval at any time, or as described below in Part E. I understand that I cannot cancel this approval when this form has already been used to disclose information.

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® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

PART D: PURPOSE OF THIS APPROVAL

☐ To give out the information as shown on this form

OR

☐ For this reason(s): _____

PART E: DATE YOUR APPROVAL EXPIRES

If this document was not already withdrawn, this approval will end on the earliest of the following dates:

☐ One year from the signature date in Part F

OR

☐ Earlier than one year and upon the date, event or condition described below

_____

PART F: REVIEW AND APPROVAL

I have read the contents of this form. I understand, agree, and allow Anthem Blue Cross to the use and release of my information as I have stated above. I also understand that signing this form is of my own free will. I understand that Anthem Blue Cross does not require that I sign this form in order for me to receive treatment or payment, or for enrollment or being eligible for benefits.

I have the right to withdraw this approval at any time by giving written notice of my withdrawal to Anthem Blue Cross. I understand that my withdrawing this approval will not affect any action taken before I do so. I also understand that information that's released may be given out by the person or group who receives it. If this happens, it may no longer be protected under the HIPAA Privacy Rule. I am entitled to a copy of this form.

Member signature or Designated Legal Representative/Guardian signature	Date
X	

DESIGNATED LEGAL REPRESENTATIVE/GUARDIAN

If this form is signed by someone other than the member or parent, such as a personal representative, legal representative or guardian on behalf of the member, please submit the following:

- A copy of a health care, general or Durable Power of Attorney.

OR

- A court order or other documentation that shows custody or other legal documentation showing the authority of the legal representative to act on the member's behalf.

Please complete the following:

Legal representative (print full name)	Legal relationship to member

Legal representative street address	City	State	ZIP code

Signature	Date
X	

Please return the completed form to:

Anthem Blue Cross

Be sure to keep a copy of this form for your records.

FOR RECIPIENT OF SUBSTANCE ABUSE INFORMATION

This information has been disclosed to you from records protected by Federal Confidentiality of Alcohol or Drug Abuse Patient Records rules (42 CFP part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

For internal use only:	Inquiry tracking number

Anthem BlueCross

(Attach one form per patient)

NON-MEMBER TRANSPLANT DONOR FORM

Date:		Product: HMO ☐ POS ☐ PPO ☐ Senior ☐ Other ☐ Contracted: Yes ☐ No ☐	
*Hospital / Facility / Physician Name:			UPIN:
Tax ID Number:	Medicare ID Number (if applicable):	NPI Number:	*Date(s) of Service: From: Through:
Office Contact Name:	Telephone Number:		Fax Number:
*Member's Last Name:	*Member's First Name:	*Member's ID Number:	Original Claim Number:
*Donor's Last Name	*Donor's First Name		

*** Indicates a required field**

INSTRUCTIONS: Please attach all supporting documentation to this form and mail to:

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

Please provide an itemized bill with the primary diagnosis code and any additional detailed information:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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Created: March 2010

Patient Consent to Exchange Information

This form is used for authorization to exchange information between healthcare providers and behavioral health providers. Please read the information below and indicate whether consent is given or declined to exchange information. The sole purpose is for continuity and coordination of care between the behavioral health providers and the healthcare providers. This form may be used with all insurance carriers.

Si usted necesita ayuda en español para entender éste documento, puede solicitarla gratis llamando al número de servicio al cliente que aparece en su tarjeta de identificación o en su folleto de inscripción.

I. Patient Consent Given

I understand the importance of communication between my healthcare provider and behavioral health provider. I give my consent to exchange information for continuity and coordination of care purposes. I understand the information on this form will only be communicated to my healthcare provider and may be faxed with the appropriate confidentiality cover sheet. *This consent expires after one year from the date of signature*. I may receive a copy of this consent upon request. Further disclosure requires my additional authorization, unless allowed for by law.

Print Patient Name _____ Patient Date of Birth _____

Patient or Guardian Signature _____ Date _____

Healthcare Provider Information

First Name _____ Last Name _____

Street Address _____ City / State _____

Telephone Number _____ Fax Number _____

The section below shall be completed by the behavioral health provider.

Dear Healthcare Provider,

I am the behavioral health provider for the above named patient, who was seen on _____ (Date) with diagnosis _____ (ICD9 Code (s)). The treatment recommendations, including lab tests, are: _____

The prescribed medication (s) are: _____

If I am not the prescribing provider, the prescribing provider is _____ (Prescribing Provider).

You may contact me at the phone number listed below.

Print Behavioral Health Provider Name _____ Telephone Number _____

Behavioral Health Provider Signature _____ Date _____

II. Patient Consent Declined

My behavioral health provider has explained the importance of communication between providers. At this time, I DO NOT give my consent to exchange information for the following reason:

_____

☐ *Declined to Provide Reason*

Print Patient Name _____ Patient Date of Birth _____

Patient or Guardian Signature _____ Date _____

PROVIDER DISPUTE RESOLUTION REQUEST

NOTE: SUBMISSION OF THIS FORM CONSTITUTES AGREEMENT NOT TO BILL THE PATIENT DURING THE DISPUTE RESOLUTION PROCESS.

INSTRUCTIONS

- Please complete the below form. Fields with an asterisk (*) are required. For the online editable form, use the tab key to move from field to field. Use the spacebar to check the appropriate boxes.
- Please complete this form if you are seeking reconsideration of a previous billing determination.
- Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed.
- In order to ensure the integrity of the Provider Dispute Resolution (PDR) process, we will re-categorize issues sent to us on a PDR form which are not true provider disputes (e.g., claims check tracers or a provider's submission of medical records after payment was denied due to a lack of documentation).
- For routine follow-up, use Secure Messaging. You can send online questions to Availity Web Portal at www.availity.com
- Mail the completed form to: Anthem Blue Cross
  P. O. Box 60007
  Los Angeles, CA 90060-0007

***PROVIDER NAME:**	***PROVIDER NPI #:**
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health ☐ Hospital ☐ ASC ☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

*** CLAIM INFORMATION** ☐ Single ☐ Substantially Similar Multiple Claims (complete attached spreadsheet)

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

☐ Claim
☐ Appeal of Medical Necessity / Utilization Management Decision
☐ Request For Reimbursement Of Overpayment
☐ Seeking Resolution Of A Previous Billing Determination
☐ Contract Dispute
☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print)	**Title**	**( ) Phone Number**
Signature	**Date**	**( ) Fax Number**

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple additional information)

For Health Plan Use Only
TRACKING NUMBER
PROVIDER ID#

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Revised May 2014

PROVIDER DISPUTE RESOLUTION REQUEST

For use with multiple "LIKE" claims (disputed for the same reason)

*PROVIDER NAME:	*PROVIDER NPI #:

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

[ ] **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED**
(Please do not staple additional information)

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Revised May 2014

Preventive health guidelines
As of May 2016

What is your plan for better health?

Make this year your best year for wellness. Your health plan may help pay for tests to find disease early and routine wellness exams to help you and your family stay well. Talk with your doctor (health care provider) about the care that is right for you.

Your plan may not pay for all services and treatments in this guide. To learn more about what your plan pays for, see your *Certificate of Coverage* or call the Customer Care number on your ID card. You also can check **anthem.com/ca** to learn about health topics from child care to zinc.

The content in this guide is based in part on suggestions from these independent groups and based on state-specific requirements:

- **AAFP** – American Academy of Family Physicians
- **AAP** – American Academy of Pediatrics
- **ACIP** – Advisory Committee on Immunization Practices
- **ACOG** – American College of Obstetrics and Gynecology
- **ACS** – American Cancer Society
- **CDC** – Centers for Disease Control and Prevention
- **USPSTF** – U.S. Preventive Services Task Force

This guide is just for your information; it is not meant to take the place of medical care or advice.

Use this guide to know when to set up visits with your doctor for you and your children. Ask your doctor which exams, tests and vaccines are right for you, when you should get them and how often. How you get certain diseases is not talked about in this guide.

Please see your plan handbook to check on your plan benefits.

Anthem BlueCross

Well-baby and child screenings

Well-baby exam — birth to 2 years*

Infants who leave the hospital less than two days (48 hours) after birth need to be seen by a doctor within two to four days after being born. You might talk to the doctor if you are a first-time parent, are having a high-risk pregnancy, or want to learn about feeding, circumcision or well-baby care. At the well-baby exam, you may get advice on your child's safety, dental exams and care, overall health, diet, physical activity and development. At these exams, your baby may get vaccines and the screenings listed below or others, such as tuberculin and sickle cell anemia, if needed.

	Age (in months)									
Screenings	**Birth**	**1**	**2**	**4**	**6**	**9**	**12**	**15**	**18**	**24**
Weight, length and head circumference (the length around the head)	At each visit									
Newborn metabolic, sickle cell and thyroid screening	Birth to 2 months									
Development and behavior	At each visit									
Hearing	As a newborn and when your doctor suggests									
Oral/dental health	At each visit**									
Hemoglobin or hematocrit (blood count)						Once between 9 and 12				
Lead testing (unless you are sure the child has not been around lead)							At 12			At 24
Autism									At 18	At 24

Well-child exam — ages 2 1/2 to 10 years*

You may get advice about how to keep your child safe, how to prevent injuries, counseling to reduce the risks of getting skin cancer, good health, diet, physical activity and development. Annual dental referrals starting at age 3 or earlier, if needed. At these well-child exams, your child may get vaccines and the screenings listed below or others, such as tuberculin and urine, if needed.

	Age (in years)								
Screenings	**2 1/2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**
Height, weight, body mass index (BMI*)**	Each year								
Development and behavior	At each visit								
Vision	Each year								
Hearing	Each year								
Oral/dental health		Fluoride**		Each year					
Blood pressure		Each year starting at 3 years							

Well-child exam — ages 11 to 18 years*

The doctor may talk to you about health and wellness issues. These include diet, exercise, healthy weight, sexual health, sexually transmitted infections, how to prevent injuries, alcohol and drugs, counseling to reduce the risks of getting skin cancer, avoiding tobacco, secondhand smoke, dental health and mental health. At these exams, your child may get vaccines and the screenings listed below or others, such as tuberculin and urine, if needed.

	Age (in years)							
Screenings	**11**	**12**	**13**	**14**	**15**	**16**	**17**	**18**
Height, weight body mass index (BMI)***	Each year							
Development and behavior	Each year							
Blood pressure	Each year							
Vision	Each year							
Hearing	Each year							
Oral/dental health	Each year							
Chlamydia	For sexually active women aged 24 and younger							

* This guide is for people enrolled in the Anthem plan. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your doctor if you have concerns about your health.

** Get fluoride varnish on the teeth when your doctor suggests. Your doctor may also give you a fluoride prescription, depending on your drinking water.

*** Height and weight is used to find BMI. BMI is used to see if a person has the right weight for height, or is under or over weight for height.

Adult screenings — women*

Well-person exam

The doctor may talk with you about health and wellness issues. These include diet, exercise, family planning and folic acid for women who are of the age to get pregnant, sexual behavior and screening for sexually transmitted infections including HIV and HBV if high risk as well as intimate partner violence. It also includes how to prevent injuries, counseling to reduce the risks of getting skin cancer, special risks you might have for cancer (such as family history) and steps you can take to manage any such risks, misuse of drugs and alcohol, how to stop using tobacco, secondhand smoke, dental health and mental health, including screening for depression. At this visit, you may get vaccines and these screenings:

Screenings	19-21	21-29	30	35	
Height, weight	Each year or as your doctor suggests				
Body mass index (BMI)	Each year or as your doctor suggests				
Blood pressure	Each year or as your doctor suggests; high measurements should be confirmed in the				
Breast cancer: doctor exam	Every one to three years				
Breast cancer: mammogram					
Cervical cancer: ages 21-29		Every three years			
Cervical cancer: ages 30-65			Should have a Pap test plus an HPV test (called		
Cervical cancer: ages 65+					
Colorectal cancer					
Chlamydia	Sexually active women ages 24 and younger				
Cholesterol					
Contraceptive methods and counseling***					
Glucose screening for Type 2 Diabetes					
Osteoporosis					
Hepatitis C					

* This guide is for people enrolled in the Anthem plan. Some people may be at higher risk for health issues due to their family history, their race or ethnicity, or other reasons. Talk to your doctor if you have concerns about your health.

** Women should talk to their health care provider and make a personal choice regarding the optimal age at which to begin screening and the potential to screen every 2 years at an older age.

*** For sexually active females.

40	45	50	55	60	65 and older
home setting					
Each year from age 40 to 65+					
Each year from age 40 to 65+**					
“co-testing”) every five years. This is the preferred approach, but it is alright to have a Pap test alone every three years.					
					Stop screening at age 65 if last three Pap tests or last two co-tests (Pap plus HPV) within the previous 10 years were normal. If there is a history of an abnormal Pap test within the past 20 years, discuss continued screening with your doctor.
		At age 50, your doctor may suggest one of these test options: 1. Fecal occult blood test (FOBT) each year 2. Flexible sigmoidoscopy every five years 3. Both #1 and #2 4. Double-contrast barium enema every five years 5. Colonoscopy every 10 years 6. CT colonography may take the place of a colonoscopy in some cases			
	Every 5 years starting at age 45, with more screenings as your doctor suggests or for women ages 20-45, if at increased risk for coronary heart disease				
As your doctor suggests, from 40 to 70, if you are overweight or obese. Individuals with high glucose should talk to their health care provider about intensive counseling interventions to promote a healthful diet and physical activity.					
		The test to check how dense your bones are should start no later than age 65; women at menopause should talk to their doctor about osteoporosis and have the test when at risk.			
		Screen once if born 1945-1965.			

Pregnant women*

Pregnant women should see their doctor or OB/GYN in their first three months of pregnancy for a first visit and to set up a prenatal care plan. At this visit, your doctor will check your health and the health of your baby.

Based on your past health, your doctor may want you to have these tests, screenings or vaccines:

- **Depression** — screening during or after pregnancy
- **Diabetes** during pregnancy
- **Hematocrit/hemoglobin** (blood count)
- **Hepatitis B**
- **HIV**
- **Rubella immunity** — to find out which women need the rubella vaccine after giving birth
- **Rh(D) blood type and antibody testing** — if Rh(D) negative, repeat test at 26 to 28 weeks
- **Syphilis**
- **Urinalysis** — when your doctor wants it

The doctor may talk to you about what to eat and how to be active when pregnant, as well as staying away from tobacco, drugs, alcohol and other substances. You also may discuss breast-feeding support, supplies and counseling.

Other tests and screenings:

Some tests given alone or with other tests can be used to check the baby for health concerns. These tests are done at certain times while you are pregnant. The best test to use and the best time to do it depends on many things. These include your age, as well as your medical and family history. Talk to your doctor about what these tests can tell you about your baby, the risks of the tests and which tests may be best for you:

- **Amniocentesis**
- **Chorionic villus sampling**
- **Special blood tests**
- **Ultrasound tests** including special tests (used with blood tests during the first three months for chromosomal abnormality risk) and routine two-dimensional tests to check on the baby

Medications:

If you are at high risk for a condition called preeclampsia, your doctor may recommend the use of low-dose aspirin, as preventive medication.

Vaccines:

If you are pregnant in flu season (October to March), your doctor may want you to have the inactivated flu vaccine. Pregnant adolescents and adults should be vaccinated with Tdap vaccine with each pregnancy. While other vaccines may be given in special cases, it is best to get the vaccines you need before you get pregnant. Women should always check with their doctor about their own needs.

You should **not** get these vaccines while you are pregnant:

- **Measles, mumps, rubella (MMR)**
- **Varicella**

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Adult screenings — men*

Well-person exam

The doctor may talk with you about health and wellness issues. These include diet, exercise, family planning, how to prevent injuries, misuse of drugs and alcohol, how to stop using tobacco, secondhand smoke, sexual behavior and screening for sexually transmitted infections including HIV and HBV (if high risk) counseling to reduce the risks of getting skin cancer, special risks you might have for cancer (such as family history) and steps you can take to manage any such risks, dental health and mental health, including screening for depression. At this visit, you may get vaccines and these screenings:

	Age (in years)					
Screenings	**19**	**20**	**25**	**30**	**35**	
Height, weight	Each year or as your doctor suggests					
Body mass index (BMI)	Each year or as your doctor suggests					
Blood pressure	Each year or as your doctor suggests; high measurements should be confirmed in the home setting					
Cholesterol					Every 5 years starting heart disease	
Colorectal cancer						
Glucose screening for Type 2 Diabetes						
Prostate cancer						
Abdominal aortic aneurysm						
Hepatitis C						

40	45	50	55	60	65 and older
at age 35, with more screenings as your doctor suggests or for men ages 20-35, if at increased risk for coronary					
		At age 50, your doctor may suggest one of these test options: 1. Fecal occult blood test (FOBT) each year 2. Flexible sigmoidoscopy every five years 3. Both #1 and #2 4. Double-contrast barium enema every five years 5. Colonoscopy every 10 years 6. CT colonography may take the place of a colonoscopy in some cases			
As your doctor suggests, from 40 to 70, if you are overweight or obese. Individuals with high glucose should talk to their health care provider about intensive counseling interventions to promote a healthful diet and physical activity.					
		If you are 50 or older, discuss with your doctor the risks and benefits of the prostate cancer tests.			
					One time for ages 65-75 if you have ever smoked
		Screen once if born 1945-1965			

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Suggested vaccine schedule*

For additional information regarding vaccinations, refer to cdc.gov/vaccines.

	Age								
Vaccine	Birth	1-2 months	2 months	4 months	6 months	6-18 months	12-15 months	15-18 months	n
Hepatitis B	✔	✔				✔			
Rotavirus (RV)			✔ Two-dose or three-dose series						
Diphtheria, tetanus, pertussis (DTaP)			✔	✔	✔			✔	
Tetanus, diphtheria, pertussis (Td/Tdap)									
Haemophilus influenza type b (Hib)			✔ Three- or four-dose series — first dose at 2 months — last dose at 12-15 months						
Pneumococcal conjugate (PCV)			✔	✔	✔		✔		
Inactivated polio virus (IPV)			✔	✔		✔			
Influenza (flu)								✔ Suggeste	
Measles, mumps, rubella (MMR)							✔		
Varicella (chickenpox)							✔		
Hepatitis A							✔ Two-dose serie		
Human papillomavirus (HPV)									
Meningococcal									
Pneumococcal 13-valent conjugate (PCV13)									
Pneumococcal polysaccharide (PPSV23)									
Zoster									

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19-23 months	4-6 years	11-12 years	13-18 years	19-60 years	60-64 years	65+ years
	✔					
		✔ Tdap		✔ Td booster every 10 years		
	✔					
ed each	year from 6 months to 65+ years of age					
	✔					
	✔					
es						
		✔ Three-dose series				
		✔	✔ At age 16			
						✔
				✔ Suggested for certain individuals at risk		✔
					✔ One single dose for ages 60+	

✔ Shows when vaccines are suggested

Hepatitis B — You may get an extra dose (four-dose series) at 4 months if the combination vaccine is used after the birth dose. If you are 18 years or older, you should get a screening if you are high risk for infection.

Rotavirus (RV) — Get two-dose or three-dose series (depends on brand of vaccine used).

Tdap (teens) — If you are 13 to 18 years of age and have not had this vaccine before, talk to your doctor about a catch-up vaccine.

Tdap (adults) — If you are 19 years of age or older and have not gotten a dose of Tdap before, you should get a single dose.

Haemophilus influenza type b (Hib) — Get three-dose or four-dose series (depends on brand of vaccine used).

Pneumococcal conjugate (PCV) — Children aged 14 months through 59 months who have received an age-appropriate series of 7-valent PCV (PCV7), administer a single supplemental dose of 13-valent PCV (PCV13).

Influenza (flu) — Refer to flu.gov or cdc.gov to learn more about this vaccine. (Children 6 months to 8 years of age having the vaccine for the first time should have two doses separated by four weeks.)

Measles, mumps, rubella (MMR) and varicella (chickenpox) — All adults born after 1957 should have documentation of one or more doses of MMR vaccine unless they have a medical contraindication to the vaccine, or laboratory evidence of immunity to each of the three diseases.

Human papillomavirus (HPV) — This vaccine is for girls (2vHPV, 4vHPV4 or 9vHPV) and boys (4HPV4 or 9vHPV) 11 to 12 years of age, but it may be given as early as 9 years of age. This vaccine can be given up to age 26. The second dose is given one to two months after the first dose. The third dose is given 24 weeks after the first dose and 16 weeks after the second dose.

Meningococcal — Two doses of this vaccine are given. The first dose at 11 or 12 years of age and the next dose at 16. Teens and young adults (16 through 23 year olds) may also be vaccinated with a serogroup B meningococcal vaccine (2 or 3 doses depending on brand), preferably at 16 through 18 years old.

Pneumococcal polysaccharide (PPSV23) — Adults 65 years and older and certain adults younger than 65 who are considered at risk are recommended to receive both a PCV13 and PPSV23. Ask your doctor about the dosing recommendation that is right for you.

Pneumococcal 13-valent conjugate (PCV13) — If you have not gotten PPSV23, you should get PCV13 first followed by PPSV23 six to 12 months later. If you have gotten PPSV23, get PCV13 12 months or more later. If you are not sure of your vaccine history, you should get PCV13 before PPSV23.

To learn more about your plan, please see anthem.com/ca.

To learn more about vaccines, please see the Centers for Disease Control and Prevention (CDC) website: cdc.gov.

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Information that's important to you

Anthem BlueCross

Every year, we're required to send you specific information about your rights, your benefits and more. This can use up a lot of trees, so we've combined a couple of these required annual notices. Please take a few minutes to read about:

- State notice of privacy practices.
- HIPAA notice of privacy practices.
- Breast reconstruction surgery benefits.

Want to save more trees? Go to anthem.com/ca and sign up to receive these types of notices by email.

State notice of privacy practices

As mentioned in our Health Insurance Portability and Accountability Act (HIPAA) notice, we must follow state laws that are stricter than the federal HIPAA privacy law. This notice explains your rights and our legal duties under state law. This applies to life insurance benefits, in addition to health, dental and vision benefits that you may have.

Your personal information

We may collect, use and share your nonpublic personal information (PI) as described in this notice. PI identifies a person and is often gathered in an insurance matter.

We may collect PI about you from other persons or entities, such as doctors, hospitals or other carriers. We may share PI with persons or entities outside of our company — without your OK in some cases. If we take part in an activity that would require us to give you a chance to opt out, we will contact you. We will tell you how you can let us know that you do not want us to use or share your PI for a given activity. You have the right to access and correct your PI. Because PI is defined as any information that can be used to make judgments about your health, finances, character, habits, hobbies, reputation, career and credit, we take reasonable safety measures to protect the PI we have about you. A more detailed state notice is available upon request. Please call the phone number printed on your ID card.

HIPAA notice of privacy practices

THIS NOTICE DESCRIBES HOW HEALTH, VISION AND DENTAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION WITH REGARD TO YOUR HEALTH BENEFITS. PLEASE REVIEW IT CAREFULLY.

We keep the health and financial information of our current and former members private, as required by law, accreditation standards and our rules. This notice explains your rights. It also explains our legal duties and privacy practices. We are required by federal law to give you this notice.

Your Protected Health Information

We may collect, use and share your Protected Health Information (PHI) for the following reasons and others as allowed or required by law, including the HIPAA Privacy Rule:

For payment: We use and share PHI to manage your account or benefits; or to pay claims for health care you get through your plan.

For health care operations: We use and share PHI for health care operations.

For treatment activities: We do not provide treatment. This is the role of a health care provider, such as your doctor or a hospital. **Examples of ways we use your information for payment, treatment and health care operations:**

- We keep information about your premium and deductible payments.
- We may give information to a doctor's office to confirm your benefits.
- We may share explanation of benefits (EOB) with the subscriber of your plan for payment purposes.
- We may share PHI with your health care provider so that the provider may treat you.
- We may use PHI to review the quality of care and services you get.
- We may use PHI to provide you with case management or care coordination services for conditions like asthma, diabetes or traumatic injury.
- We may also use and share PHI directly or indirectly with health information exchanges for payment, health care operations and treatment. If you do not want your PHI to be shared for payment, health care operations, or treatment purposes in health information exchanges, please visit anthem.com/ca/health-insurance/about-us/privacy for more information.

To you: We must give you access to your own PHI. We may also contact you to let you know about treatment options or other health-related benefits and services. When you or your dependents reach a certain age, we may tell you about other products or programs for which you may be eligible. This may include individual coverage. We may also send you reminders about routine medical checkups and tests.

To others: In most cases, if we use or disclose your PHI outside of treatment, payment, operations or research activities, we must get your OK in writing first. We must receive your written OK before we can use your PHI for certain marketing activities. We must get your written OK before we sell your PHI. If we have them, we must get your OK before we disclose your provider's psychotherapy notes. Other uses and disclosures of your PHI not mentioned in this notice may also require your written OK. You always have the right to revoke any written OK you provide.

You may tell us in writing that it is OK for us to give your PHI to someone else for any reason. Also, if you are present and tell us it is OK, we may give your PHI to a family member, friend or other person. We would do this if it has to do with your current treatment or payment for your treatment. If you are not present, if it is an emergency, or you are not able to tell us it is OK, we may give your PHI to a family member, friend or other person if sharing your PHI is in your best interest.

As allowed or required by law: We may also share your PHI for other types of activities including:

- Health oversight activities.
- Judicial or administrative proceedings, with public health authorities, for law enforcement reasons, and with coroners, funeral directors or medical examiners (about decedents).
- Organ donation groups for certain reasons, for research, and to avoid a serious threat to health or safety.
- Special government functions, for Workers' Compensation, to respond to requests from the U.S. Department of Health and Human Services, and to alert proper authorities if we reasonably believe that you may be a victim of abuse, neglect, domestic violence or other crimes; and
- As required by law.

If you are enrolled with us through an employer-sponsored group health plan, we may share PHI with your group health plan. If your employer pays your premium or part of your premium, but does not pay your health insurance claims, your employer is not allowed to receive your PHI — unless your employer promises to protect your PHI and makes sure the PHI will be used for legal reasons only.

Authorization: We will get an OK from you in writing before we use or share your PHI for any other purpose not stated in this notice. You may take away this OK at any time, in writing. We will then stop using your PHI for that purpose. But if we have already used or shared your PHI based on your OK, we cannot undo any actions we took before you told us to stop.

Genetic information: We cannot use or disclose PHI that is an individual's genetic information for underwriting.

Race, Ethnicity and Language: We may receive race, ethnicity and language information about you and protect this information as described in this Notice. We may use this information for various health care operations, which include identifying health care disparities, developing care management programs and educational materials and providing interpretation services. We do not use race, ethnicity and language information to perform underwriting, rate setting or benefit determinations, and we do not disclose this information to unauthorized persons.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, including a request to receive a copy of your PHI through email. It is important to note that there is some level of risk that your PHI could be read or accessed by a third party when it is sent by unencrypted email. We will confirm that you want to receive PHI by unencrypted email before sending it to you.
- Ask that we correct your PHI that you believe is missing or incorrect. If someone else (such as your doctor) gave us the PHI, we will let you know so you can ask him or her to correct it.
- Send us a written request to ask us not to use your PHI for treatment, payment or health care operations activities. We are not required to agree to these requests.
- Give us a verbal or written request to ask us to send your PHI using other means that are reasonable. Also, let us know if you want us to send your PHI to an address other than your home if sending it to your home could place you in danger.
- Send us a written request to ask us for a list of certain disclosures of your PHI. Call Customer Service at the phone number printed on your identification (ID) card to use any of these rights. Customer Service representatives can give you the address to send the request. They can also give you any forms we have that may help you with this process.

- Right to a restriction for services you pay for out of your own pocket: If you pay in full for any medical services out of your own pocket, you have the right to ask for a restriction. The restriction would prevent the use or disclosure of that PHI for treatment, payment or operations reasons. If you or your provider submits a claim to Anthem Blue Cross (Anthem), Anthem does not have to agree to a restriction (see Your Rights section above). If a law requires the disclosure, Anthem does not have to agree to your restriction.

How we protect information

We are dedicated to protecting your PHI, and have set up a number of policies and practices to help make sure your PHI is kept secure.

We have to keep your PHI private. If we believe your PHI has been breached, we must let you know.

We keep your oral, written and electronic PHI safe using physical, electronic, and procedural means. These safeguards follow federal and state laws. Some of the ways we keep your PHI safe include securing offices that hold PHI, password-protecting computers, and locking storage areas and filing cabinets. We require our employees to protect PHI through written policies and procedures. These policies limit access to PHI to only those employees who need the data to do their job. Employees are also required to wear ID badges to help keep people who do not belong out of areas where sensitive data is kept. Also, where required by law, our affiliates and nonaffiliates must protect the privacy of data we share in the normal course of business. They are not allowed to give PHI to others without your written OK, except as allowed by law and outlined in this notice.

Potential impact of other applicable laws

HIPAA (the federal privacy law) generally does not pre-empt, or override, other laws that give people greater privacy protections. As a result, if any state or federal privacy law requires us to provide you with more privacy protections, then we must also follow that law in addition to HIPAA.

Contacting you

We, including our affiliates or vendors, may call or text any telephone numbers provided by you using an automated telephone dialing system and/or a prerecorded message. Without limitation, these calls may concern treatment options, other health-related benefits and services, enrollment, payment, or billing.

Complaints

If you think we have not protected your privacy, you can file a complaint with us. You may also file a complaint with the Office for Civil Rights in the U.S. Department of Health and Human Services. We will not take action against you for filing a complaint.

Contact information

Please call Customer Service at the phone number printed on your ID card. Representatives can help you apply your rights, file a complaint or talk with you about privacy issues.

Copies and changes

You have the right to get a new copy of this notice at any time. Even if you have agreed to get this notice by electronic means, you still have the right to a paper copy. We reserve the right to change this notice. A revised notice will apply to PHI we already have about you, as well as any PHI we may get in the future. We are required by law to follow the privacy notice that is in effect at this time. We may tell you about any changes to our notice in a number of ways. We may tell you about the changes in a member newsletter or post them on our website. We may also mail you a letter that tells you about any changes.

Effective date of this notice

The original effective date of this Notice was April 14, 2003. The most recent revision date is indicated in the footer of this Notice.

Breast reconstruction surgery benefits

If you ever need a benefit-covered mastectomy, we hope it will give you some peace of mind to know that your Anthem benefits comply with the Women's Health and Cancer Rights Act of 1998, which provides for:

- Reconstruction of the breast(s) that underwent a covered mastectomy.
- Surgery and reconstruction of the other breast to restore a symmetrical appearance.
- Prostheses and coverage for physical complications related to all stages of a covered mastectomy, including lymphedema.

All applicable benefit provisions will apply, including existing deductibles, copayments and/or coinsurance. Contact your plan administrator for more information.

For more information about the Women's Health and Cancer Rights Act, you can go to the federal Department of Labor website at: dol.gov/ebsa/publications/whcra.html.

EFFECTIVE March 1, 2016

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Remittance Advice Field Descriptions

Service Date(s)	The dates of service for the specific line items of detail of the claim.
Service Code	The procedure (CPT / HCPCS) code assigned to the service(s) received by the member for that date of service (DOS).
Charged Amount	The amount a provider billed Blue Cross for the service.
Allowed Amount	The provider's schedule of maximum allowable amounts for the service provided.
Not Allowed Amount / MSG	The amount not allowed by Blue Cross.
Deduct Amount	The amount that must be paid by the patient, which is determined by the member's contract benefits.
Copay Amount	The amount that must be paid by the patient, which is determined by the member's contract benefits.
Coins Amount	The amount that must be paid by the patient, which is determined by the member's contract benefits.
Discount Amount	The amount that exceeds the "Allowed Amount," which cannot be billed to the patient (the **"write-off** "amount).
Units / POS	Number of Units: Units of Service provided. Place of Service: "1" indicates an inpatient claim; "2" indicates an outpatient claim.
Paid Amount	The "Allowed Amount" minus the "Deductible Amount" minus the "Copayment Amount," or the "Allowed Amount" minus the member's financial responsibility, is the Blue Cross claims payment.

Anthem Blue Cross

P.O. BOX 70000
VAN NUYS, CA
91470-0001

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REMITTANCE ADVICE

ISSUE DATE	PAGE E000004
December 18, 2008	0001 OF 00----

WellPoint Memorial Hospital
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 391594568 200800006

Provider ID: 391594568

Insured's Name: SCHILLING, NANCY
DCN #: 08263151035
Patient Acct #: FAITH F

Insured's ID: 800A06073
Apprd Days: 001 Paid Days 001
Ntwk: Participating Provider

Patient Name: SCHILLING, NANCY
DRG Rcvd: DRG Paid:
Ntwk Claim # :

SERVICE DATE(s)	SERVICE CODE	CHARGED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT / MSG	DEDUCT AMOUNT	COPAY AMOUNT	COINS AMOUNT	DISCOUNT AMOUNT	UNITS / POS	PAID AMOUNT
12/01/08 12/01/08	0450	450.00	375.00			75.00			001 / 2	300.00
12/01/08 12/01/08	0250	25.00							001 / 2	0.00
12/01/08 12/01/08	270	75.00							001 / 2	0.00
CLAIM TOTAL		550.00	375.00	0.00	0.00	75.00	0.00	0.00		300.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: (800) 333-0912

Revised: 07/13

Anthem BlueCross

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Timely Filing Acceptable Forms of Proof

Forms of Acceptable Proof	Items to Verify Acceptable Proof
Electronic	
Clearinghouse report demonstrating actual submission of claim to Anthem Blue Cross [Anthem] EDI Gateway within the timely filing limit.	• Proof must be from a clearinghouse and must either show: (a) the actual Anthem response to the submission of the electronic claim, (b) a positive acceptance message from Anthem, or (c) a report from the facility or its clearinghouse objectively demonstrating that the claim was in fact submitted to Anthem. • Submission dates must be included and be within the filing limits from the DOS.
Level 2 Status Reports generated by Anthem EDI Gateway demonstrating submission of claim or acceptance of claim within timely filing limit.	• Verify that the claim was received and accepted for processing. • Confirm the date of submission is within the filing limits.
Dated request for additional information from Anthem (Mailback).	• Ensure dates are within the filing limitations from DOS to Anthem letter date.
Claim denial letter or RA / EOB from Anthem.	• Verify member information and dates of service. • Ensure RA / EOB / Denial letter date demonstrates that facility's submission was within the filing limit.
For EDI claims, which could not be processed by Anthem.	• Anthem letter must indicate the original submission was within the filing limit; or • A batch number or error report must be included to verify submission to Anthem.
Hard Copy	
Computer-generated claim transaction history with the Anthem name from a billing system.	• Correct Anthem address must be indicated (on ledger or a code listing). • Must include complete billing history. • Follow-up attempts must be made consistently and within a reasonable amount of time. • Follow-up information must include dates, names, and other pertinent details.
Dated request for additional information from Anthem (Mailback).	• Ensure dates are within the filing limitations from DOS to Anthem letter date.
Claim denial letter or RA / EOB from Anthem.	• Verify Member information and dates of service. • Ensure RA / EOB / Denial letter date demonstrates that facility's submission to Anthem was within the filing limit.
Denial letter from other insurance carrier, dated and printed on letterhead.	• Letter must have valid letterhead. • Letter must be dated. • Claim to Anthem must be within the filing limit starting from the date of the letter.
Dated RA / EOB from other insurance carrier.	• RA / EOB must demonstrate that submission to other insurer was within Anthem's timely filing limit. • Claim to Anthem must be within the filing limit starting from the date of the RA / EOB.
Proof of member billing.	• Patient billing history must demonstrate follow-up attempts within a reasonable period of time. • Follow-up attempts must be made within the timely filing limit.

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