Professional Manual

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March 2015

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Using this Manual

The *Anthem Blue Cross Professional Manual* (alternatively referred to as the "Provider Operations Manual," "Provider Manual" or "Operations Manual") is a comprehensive document designed to inform Professional Providers (those that bill on a *CMS-1500 Claim Form*, which are hereinafter referred to as "Providers") and their staff of certain of Anthem Blue Cross' guidelines and requirements. Throughout the Manual, Anthem Blue Cross may be referred to as Anthem Blue Cross, Anthem, Plan or the Company. All of the processes and procedures set forth in this Manual shall become effective on July 6, 2015 and are applicable to all claims submitted on or after the effective date of the Manual.

This Manual applies to Providers contracted under the Anthem Blue Cross Comprehensive Participating Provider Agreement, Prudent Buyer Plan Participating Physician Agreement or Select PPO Addendum, Anthem Blue Cross Participating Mental Health Practitioner Agreement, and the Anthem Blue Cross Provider Agreement. Throughout this Manual, any references to the Agreement shall be meant to refer to those listed above unless otherwise indicated.

When information in the Manual conflicts with that in the *Anthem Blue Cross Comprehensive Participating Provider Agreement*, *Prudent Buyer Plan Participating Physician Agreement* or *Select PPO Addendum*, *Anthem Blue Cross Participating Mental Health Practitioner Agreement*, and the *Anthem Blue Cross Provider Agreement* (Agreement), the Agreement takes precedence over the Manual.

Also, throughout the Manual, any reference of Provider also means "Physician," "Other Health Care Professional," "Participating Practitioner" and "Network/Participating Provider."

Manual Search Tool

There may be instances 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 process, refer to the "Manual Search Tool" located in our *Exhibits* section of this Manual.

Purpose and Introduction

We appreciate your participation in Anthem Blue Cross' Professional Provider Network(s). Anthem Blue Cross is committed to working with Providers to provide a high level of satisfaction in delivering quality care to our Covered Individuals. The *Anthem Blue Cross Professional Manual* is an integral part of this commitment, providing information on key contractual terms, products, eligibility, admissions procedures, claims submission and medical management guidelines as well as a directory of resources. In summary, this Manual communicates administrative and billing requirements. As Anthem Blue Cross makes changes to these requirements, this Manual will serve as a vehicle for communicating these changes.

Throughout this Manual, any reference of Member, Subscriber also means "Covered Individual."

Note: The mouse icon is used to indicate information accessible through the ProviderAccess® secure portal. Although not limited to, you have access to proprietary information such as Anthem Blue Cross Manuals, fee schedules, and BlueCard Claims Advisor. To login to ProviderAccess, go to provider2.anthem.com/wps/portal/ebpmybcc

The mouse icon also indicates information accessible through the Availity Web Portal (Availity) availity.com. Eligibility, Benefits and Claim Status Inquiry are available exclusively through Availity.

! You must have a ProviderAccess and Availity Web Portal account to access the information; only authorized users can access these secure Provider portals. For more detailed information, please refer to the *ProviderAccess→ and the Availity Web Portal (Availity)* section.

As necessary, Anthem Blue Cross will update the Manual on ProviderAccess® and Availity to provide you with the most current Anthem Blue Cross policies and procedures. If you are registered, simply enter your user ID and password. If you do not have a user ID and password, you can request an account by logging in to https://provider2.anthem.com/wps/portal/ebpmybcc and clicking on the "Request an Online Account" link from the home page. For more information about our Provider portals, refer to the *ProviderAccess→ and the Availity Web Portal (Availity)* section of this Manual.

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 Blue Cross provides contracting Providers with an accurate and up-to-date Professional Manual. However, there may be instances when new procedures or processes are not immediately reflected in the Manual. In such cases, Anthem Blue Cross will make every effort to distribute updated documentation in the next Manual update.

If you have additional questions about the *Anthem Blue Cross Professional Manual,* contact your Network specialist or the Provider Care department. Telephone numbers are provided in the *Directory of Services* section of this Manual.

Included in This Manual

The *Anthem Blue Cross 2015 Professional Manual* is divided into the following 40 sections:

1. Introduction and Guide to Manual

This section defines the purpose and serves an overview of each section of the *Anthem Blue Cross Professional Manual.*

2. Directory of Services

This section provides contact information for Anthem Blue Cross personnel and departments that are available to address your inquiries.

3. Rights and Responsibilities

This section describes Covered Individual rights and Provider responsibilities, as part of the Anthem Blue Cross Professional Networks. Information is provided on access standards, emergency care, dispute resolution processes, Health Insurance Portability and Accountability Act (HIPAA) and other legislation, and additional resources.

4. ProviderAccess® and the Availity Web Portal (Availity)

This section introduces you to Anthem's secure Provider portals: ProviderAccess and the Availity Web Portal. These portals are your online connection to eligibility, benefit and claims information, as well as other resources to make your job easier.

5. Eligibility

This section addresses eligibility and benefit verification procedures for Covered Individuals of Anthem Blue Cross and other Blue plans. It also discusses options for verifying eligibility using Availity, ID cards, appropriate Anthem Blue Cross representatives or interactive voice response (IVR).

6. 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. An overview of hard copy and electronic billing is included, as well as contact information for electronic data interchange (EDI) products and services. Information regarding BlueCard® claims is also provided in this section.

7. Ambulance

Helpful information for Ambulance Network Providers on claims submission.

8. Audiology/Hearing Aid Dispensers

This section outlines billing guidelines for Audiologists and Hearing Aid Dispensers to submit claims.

9. Diagnostic Imaging

This section outlines general and specific billing guidelines for Diagnostic Imaging Providers.

10. Durable Medical Equipment

This section outlines billing guidelines for Durable Medical Equipment Providers.

11. Home Infusion Therapy

This section outlines general and specific guidelines to assist Home Infusion Therapy Providers submit claims.

12. Laboratory

This section outlines general and specific billing guidelines for submitting claims.

13. Medical Specialty Pharmacy

This section provides information about Medical Specialty Pharmacy.

14. Physical, Occupational and Speech Therapy

This section helps Physical, Occupational and Speech Therapists submit claims.

15. Submitting Changes

This section provides information on how to submit Provider changes to Anthem Blue Cross for participating ancillary Providers. There are specific requirements depending on the type of Provider and contractual relationship.

16. Reimbursement

This section provides information on reimbursement and pricing. It outlines other reimbursement sources from which a Blue Cross PPO, Select PPO or Medicare Advantage PPO (Medicare Advantage) health care professional may seek payment (e.g., third-party liability). The section also reviews the procedures for seeking excess claim payments, referred to as overpayment and recovery.

17. Medical Management Programs

This section explains Anthem Blue Cross' Utilization Management (UM) programs, including the Medical Necessity review process, access to decision-making criteria, pre-service review, concurrent review, discharge planning and post-service review, Care Management (Case Management/Disease Management; CM/DM), and Behavioral Health Management. This section also addresses Provider responsibilities, referrals to nonparticipating Providers, review initiation and physician reviewers, Federal Employee Program guidelines and the on-site utilization program.

18. Covered Individual Grievances and Appeals Process

This section discusses the Anthem Blue Cross grievances and appeals process, including pharmacy prior authorization and background information on the submission process, staff and scope of responsibility, determinations, emergency care, definitions, and additional dispute resolution mechanisms available to Covered Individuals. Provider dispute resolution processes are explained, and information and forms are provided for the release of protected health information. In addition, this section contains information about a Covered Individual's right to independent medical review for investigational and experimental treatment denials.

19. Quality Improvement

This section describes how Anthem Blue Cross measures quality improvement, and access and availability of care. This section also addresses access standards for behavioral health care professionals, Covered Individual experience and satisfaction, continuity and coordination of care, clinical guidelines, and other available programs. Additional information is included in this Manual.

20. Credentialing

This section describes the Anthem Blue Cross credentialing process for all contracted Providers. Information regarding reduction, suspension and termination of Provider status is included.

21. Pharmacy Program and Guidelines

This section describes provisions and processes of the Anthem Blue Cross Pharmacy program. Pharmaceutical management is discussed, including the Preferred Drug Program and exception process, disclosure of Formulary medications, quantity supply limits, copayment structure and other drug programs. In addition, the section addresses prior authorization of pharmacy benefits, and access to non-Formulary medication.

22. Workers' Compensation

This section provides an overview of the Anthem Blue Cross' Workers' Compensation program, including the Medical Provider Network (MPN), and the rules and regulations for physicians.

23. Product Summary

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

24. Glossary

This section defines many of the terms used throughout this Manual and in other Anthem Blue Cross Provider documents such as the Agreement. These terms describe various products, contracted Providers, organizations and specialized services that relate to managed care. The *Glossary* also includes an overview of the Anthem Blue Cross Professional, Institutional and Ancillary Networks.

25. 360° Health®

This section describes the Preventive Health Services and ConditionCare Programs available to Anthem Blue Cross Covered Individuals with Asthma, Chronic Obstructive Pulmonary Disease (COPD), Congestive Heart Failure (CHF), Coronary Artery Disease (CAD) or Diabetes.

26. Medical Policy

This section describes the medical policy formation process.

27. Medicare Crossover

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).

28. Medicare Advantage

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

29. Anthem Centers of Medical Excellence

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

30. Dispute Resolution Process for Contracted Providers

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

31. Links

This section provides website addresses in alphabetical order.

32. Audit

This section describes the Enterprise Audit Policy.

33. Telehealth

This section describes the Anthem Blue Cross California Telehealth Services Bulletin that supports the requirements under California AB415.

34. Health Insurance Marketplace (Exchanges)

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.

35. Exhibits

This section contains useful forms for communicating with Anthem Blue Cross, as well as flowchart tools, samples of *Explanations of Benefits* (EOBs) and letters. In addition, sample ID cards are displayed to help you recognize Anthem Blue Cross plans and coverage.

36. Appendix A – Affiliates List

A list of Anthem Blue Cross affiliates. These are organizations that are owned or controlled, either directly or through parent or subsidiary corporations, by Anthem Blue Cross, or are under common control with Anthem Blue Cross.

37. Appendix B – Other Payors List (Network Leasing)

Refers to Anthem Blue Cross' Network leasing arrangements and lists Other Payors.

38. Appendix C – Notice of Privacy Practices

This notice explains our Covered Individuals' rights, our legal duties and our privacy practices.

39. Appendix D – Out-of-Network Providers for Select PPO

A list of hospitals and other facilities/ancillary Providers, which do not participate in the Select PPO Network.

40. Summary of Changes

The Summary of 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 July 6, 2015.

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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. The directory identifies service units and Anthem Blue Cross personnel that have the required expertise to address questions, issues and concerns. For additional information, access the Anthem Blue Cross website at anthem.com/ca, select *Providers*.

360° Health®

360° Health	Telephone
ConditionCare Programs	Number varies by client; please contact customer service on back of Member's ID card

AIM Specialty Health (AIM) Call Center

Service Area	Telephone	Website
AIM Specialty Health (AIM Call Center) (Elective nonemergency diagnostic imaging procedures, cardiology, specialty pharmacy, sleep studies & treatment, and the cancer care & quality program ,medical oncology, radiation oncology, and genetic testing.)	877-291-0360 (Authorization)	ProviderAccess® at https://providerportal.com/

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

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

Anthem Blue Cross Life and Health Insurance Company

Area	Telephone
Anthem Blue Cross Life and Health Insurance Company	anthem.com/ca

Availity Web Portal (Availity)

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. **Obtain eligibility, benefits, claims status, Secure** Messaging, EPA, Interactive Care Reviewer, and Remittance Advice Inquiry.	availity.com 1-800-AVAILITY (282-4548) Toll Free Monday through Friday 5 a.m. to 4 p.m. PST

Behavioral Health Care Management/Utilization Review

Not all plans require preauthorization or Case Management/Utilization Review. Call Customer Service to determine benefits, eligibility and authorization requirements. Below is the telephone number for preauthorization or Case 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 Covered Individuals. Not all Anthem Covered Individuals are covered for ABA. Call Provider Care at the number on the Member's health ID card to confirm benefits and eligibility.

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

Behavioral Health Network Medical Director

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

Behavioral Health Network Provider Relations

Behavioral Health Network Provider Relations is the liaison between Anthem Blue Cross and participating Behavioral Health Providers. Provider Relations associates are contracting support for Participating Providers and Groups. To contact the Provider Relations, email your inquiry to:

Email Address
BHNetworkRelations@anthem.com

When emailing your inquiry, include the following information to expedite our response to you:

1. Provider's tax identification number(s)
2. Medical group or Provider's nine-digit tax ID number and NPI number
3. Provider's name and license number
4. Complete contact name (company name, if not the same as Provider) and phone number, including extension number
5. Detailed description of your question or inquiry

If you have questions about your rate (fee) schedule, contract (Agreement) language or requirements as specified in the Anthem Blue Cross Professional Provider Manual, email our Behavioral Health Provider Relations team.

Behavioral Health Provider Resources

The Web page, **Behavioral Health Provider Resources** is a comprehensive resource link to specific behavioral health information. Get the information you need instantly!

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

This consolidated Provider Web page found on anthem.com/ca enhances our online presence and serves as a "one-stop shop" for California behavioral health information and resources.

Go to anthem.com/ca, select *Providers*. When our 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, contact Behavioral Health Provider Relations by email at BHNetworkRelations@anthem.com

BlueCard® Eligibility and Membership Contact Information

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

Area/Contact	Telephone
BlueCard® PPO Information about participating Providers, hospitals, Facilities or other health care professionals	800-810-BLUE (2583)
Blue Cross and Blue Shield Eligibility & Benefits (out of area) Monday through Friday, 4:30 a.m. to 5 p.m. PST	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 Covered Individuals should be directed to contact Anthem Blue Cross Life and Health if they have a question or complaint. However, if the problem is not resolved, they can either call or email the CDI.

Area	Telephone
Inside California	800-927-HELP (4357)
Outside California	213-897-8921
Telecommunication Device for the Deaf	800-482-4833 (TDD)

Mailing Address	Email Address
California Department of Insurance Consumer Services Division 300 South Spring Street South Tower Los Angeles, CA 90013	"Consumer" 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 *Covered Individual Grievances and Appeals Process* section in this Manual.

1. Mailing Address
Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95817-2725

Service	Contact Information
Health Plans Division Complaints	888-HMO-2219 916-255-5241 (Fax)
Health Plans Division California Relay Service	800-735-2929 (TTY)
DMHC internal TDD line	877-688-9891 (TDD)
DMHC's websites (online complaint forms and instructions)	healthhelp.ca.gov DMHC.ca.gov

California Public Employees Retirement System (CalPERS)

Area	Telephone
CalPERS	877-737-7776

Case Management/Disease Management

Area	Contact Information
Case Management/Disease Management Commercial HMO/PPO Anthem Blue Cross Attn: Case Management P.O. Box 4307 Woodland Hills, CA 91365-4037	888-613-1130 800-947-4074 (Fax) Email: Case.Management@anthem.com
Transplant Case Management	888-574-7215
Senior Secure Case Management	866-797-9884

Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) regulates Medicare Advantage insurers. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company products are regulated by CMS. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company Covered Individuals should be directed to contact Anthem Blue Cross or Anthem Blue Cross Life and Health if they have a question or complaint. However, if the problem is not resolved, they can either call or email CMS. See contact information below.

Claims and Correspondence Mailing Addresses

Telephone	Website Address
800-MEDICARE (800-633-4227) 877-486-2048 (TTY) Available 24 hours a day, seven days a week	mymedicare.gov Online chat services are also available

In an effort to make medical claims submission faster and easier, 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
All professional claims and claims-related correspondence for Federal Employee Program	Blue Shield of California P.O. Box 272510 Chico, California 95927
Claims and correspondence via Federal Express, registered or certified mail, etc.	Anthem Blue Cross/Name of Product 21555 Oxnard Street, 8A Woodland Hills, CA 91367
Workers' Compensation – all related correspondence. Claims should be submitted directly to the Workers' Compensation payor.	Anthem Workers' Compensation P.O. Box 70022 Anaheim, CA 92825-0022

Credentialing Status Inquiry Line

To check on the status of a credentialing application, send email to: To check on the status of a credentialing application, send email to: credentialing@anthem.com. This email is to be used only to check status of a submitted Provider application.

Customer Service

All inquiries from Anthem Blue Cross PPO Covered Individuals 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 Covered Individuals removal following disciplinary actions
- Claim status
- Claims address

Providers can access most Customer Service resources through the Provider Care department (PCD), Anthem Blue Cross' 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
Provider Care	Call the phone number on the back of the Member's ID card.

Electronic Data Interchange (EDI)

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 EDI, contact an EDI Specialist at:

EDI Solutions	
Hours available	8 a.m. to 4:30 p.m. PST
Live Chat	anthem.com/edi – Select California
Telephone	800-470-9630
Website Address	anthem.com/edi – Select California
Email Address	anthem.com/edi – Select California

Should Provider or Facility 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 or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

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

Grievances and Appeals

Contact information for assistance with grievances and appeals:

Behavioral Health Grievances & Appeals Department		
Mailing Address	Telephone	Fax
Anthem Blue Cross Behavioral Health Grievances & Appeals P.O. Box 4310 San Diego, CA 91365-4310	800-227-3851 TDD 866-333-4823	877-487-7394

HMO and PPO: Covered Individuals		
Mailing Address	Telephone	Fax
Anthem Blue Cross Grievances and Appeals Department P.O. Box 4310 Woodland Hills, CA 91365-4310	800-365-0609 TDD 866-333-4823	877-551-6183

Medicare HMO and PPO Medicare Grievances & Appeals Department		
Mailing Address	Telephone	Fax
Anthem Blue Cross Medicare Complaints Grievances & Appeals 4361 Irwin Simpson Rd OH0102-C535 Mason, OH 45040	Customer Service Number on Member ID Card	888-458-1406

Medical Provider Network (MPN) Covered Individuals must call the Anthem Workers' Compensation MPN Services 866-700-2168.

Area (Physician) Contact	Telephone
Anthem Blue Cross Grievances and Appeals Laurence Miller, MD Medical Director	619-733-2331

Area (Physician) Contact	Telephone
Behavioral Health Grievances and Appeals Robert Friedman, MD, Medical Director	858-571-8129

Language Assistance Program

At Anthem Blue Cross, 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 Covered Individuals at no cost. Certain Covered Individuals 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 Covered Individuals in the languages required by the language assistance regulations.

Translation

To ensure the timely translation of materials, encourage the Member to contact Anthem Blue Cross by calling 888-254-2721. Alternately, you can call Anthem Blue Cross at 800-677-6669 t to request translation on the Member's behalf.

Interpretation

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

Medicaid Managed Care

For information on Anthem Blue Cross Medicaid Programs for Medicaid Managed Care, Healthy Families, AIM, and MRMIP refer to the *Provider Operations Manual* for Medicaid Managed Care, which can be found on the Anthem Blue Cross website at provider2.anthem.com/wps/portal/ebpmybcc

Medical Quality Management

Area Contact	Telephone
Utilization Management Jacob Asher, MD, RVP Sr Clinical Officer-CA	415-265-0727
Medical Policy and Review Jacob Asher, MD, RVP Sr Clinical Officer-CA	415-265-0727
Anthem Blue Cross Credentials Committee Lynn Cooman, MD, Medical Director	818-307-8762
Comprehensive Health Solutions and Quality Management Jacob Asher, MD, RVP Sr Clinical Officer-CA	415-265-0727

Medical Policy & Technology Assessment

Area Contact	Telephone
Office of Medical Policy & Technology Assessment John F. Whitney, MD, Vice President, Medical and Clinical Pharmacy Policy	312-234-7746

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.

Anthem Blue Cross Preferred℠ is a Medicare Advantage Preferred Provider Organization (PPO) plan for Medicare beneficiaries.

Most Medicare Advantage and Medicare Supplement claims are received directly from Medicare; it is virtually claims-free processing for most Anthem Blue Cross Medicare Advantage and Medicare Supplement Plan Covered Individuals and their Providers.

However, if necessary, claims can be mailed to the following address:

Mailing Address
Anthem Blue Cross Senior Services P.O. Box 60007 Los Angeles, CA 90060

Covered Individual Services Information for Anthem Blue Cross Senior Services

Department	Telephone
Anthem Blue Cross Senior Services for Covered Individuals	888-230-7338 - HMO 877-811-3107 - PPO
The hours of operation seven days a week are:	
Monday through Sunday	8 a.m. to 8 p.m. PST

National Provider Solutions (NPS)

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

Contract Pricing

If you are requesting the maximum customary charges for a procedure code, fax your requests on letterhead, with current allowable amounts, to Network Relations at 818-234-3148.For a sample of the pricing form, see *Request for Prudent Buyer Plan Pricing*.

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. 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 Blue Cross. 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 Blue Cross 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).

To contact the Network Services department, listen for the appropriate network before making a selection.

! NOTE: For Behavioral Health, click *here* for *Behavioral Health Provider Relations*.

Network Services Hours of Operation	Email Address
Monday through Thursday 9 a.m. to 4 p.m. PST	CAcontractsupport@anthem.com

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

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

When applicable, also provide:

6. Patient's name
7. Patient's Health Care Identification (HCID) number
8. Dates of service
9. Total charges

Network Services can respond to questions or complaints regarding Anthem Blue Cross operations and policies including, but not limited to, noncapitated claims reporting, noncapitated performance settlements, encounter reporting, capitation payments, eligibility and enrollment protection claims.

To forward correspondence via UPS, or registered or certified mail, etc.:

Mailing Address
Anthem Blue Cross Attn: [Anthem Blue Cross Name of Product] Specific Department 21555 Oxnard Street, 8A Woodland Hills, CA 91367

Overpayment Recovery Procedures

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

Service Area	Telephone
Large Group	818-234-3289
Individual Plans	818-234-3289
Small Group	818-234-3289
BlueCard®	800-444-2726
Medicare Advantage HMO/PPO	818-234-3289
FEP	800-824-8839

Pharmacy Management

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

ProviderAccess®

ProviderAccess	
ProviderAccess® Web portal	provider2.anthem.com/wps/portal/ebpmybcc

ProviderAccess Login and Technical Support	
For support with ProviderAccess registration, Account Administrator changes, technical support, password resets or issues re-accessing the portal, contact us at:	866-755-2680 Email: provideraccess.pins@anthem.com Monday through Friday 5 a.m. to 5 p.m. PST

Provider Care

Service Area	Telephone Number
Provider Care	Call the Customer Service number on the back of the Member's ID card.

Provider Care Customer Service Operating Schedule
Monday through Friday, 7:30 a.m. to 5 p.m. PST For speech and hearing impaired assistance: Monday through Friday, 7:30 a.m. to 5 p.m. PST

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

- Eligibility verification and research
- Benefits questions and explanations
- Requests for removing Covered Individuals because of disciplinary problems

Please contact the following areas directly for assistance:

Department	Service Unit	Telephone
Anthem Blue Cross Federal Employee Program (FEP)	Customer Service	800-322-7319 (Hospital claims) 800-824-8839 (Professional claims)

Department	Service Unit	Telephone
BlueCard® (Out-of-Area Blue Cross and Blue Shield Covered Individuals)	Eligibility & Membership Line	800-676-BLUE or 800-676-2583
	Claims Status	800-444-2726
Electronic Data Interchange (EDI) Claims Submission	Customer Service	800-470-9630
Anthem Workers' Compensation	Bill Review Services	855-766-3719 (Claims) 866-700-2168 (Medical Provider Network)

Provider Data Management

Provider Data Management (PDM) handles "Provider Change Request." For information on the *Provider Change Request,* refer to the *Physicians Rights and Responsibilities* section.

Email Address (Shared Mailbox)
ProviderDatabaseAnthem@anthem.com

! Provider Network Education and eSolutions

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 "Tools for Success" 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 seminars as well as Internet-based training opportunities in the form of webinars and self-paced, on-demand "e-courses."

Complimentary Seminars

Come and enjoy an exchange of information between Anthem Blue Cross staff and your staff on a variety of topics. These seminars are offered to Anthem Blue Cross contracted health care professionals at many locations throughout the state during the fall. For locations and registration information, go to anthem.com/ca select *Providers* and check the "Spotlight" summary.

ESolutions – Webinars and 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 PC. These e-learning tools are designed to allow us to reach out to the geographic diversity of our statewide Provider community. These eSolutions are offered in the form of:

- Webinars: "live" interactive seminars conducted remotely through the Internet and facilitated by the Network Education team and Subject Matter Experts (SME). Recordings are available on request.
- On-demand, e-courses: a self-paced instructional environment where you can select the topic of your choice, go as fast or slow as you wish, all in the comfort of your office and at the convenience of your PC, 24/7/365.

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 top of the landing page and click "Enter." On the Provider Home page, under the "Health & Wellness" tab (on the blue toolbar) select "Quality Improvement and Standards."

Regulatory Management Department

See the *Grievances and Appeals* subsection earlier in this chapter.

Third Party Administrator (TPA)

For eligibility, claims status and customer service, please contact the TPA. For contractual allowances/claim pricing please contact Anthem Blue Cross 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	800-688-3828
MCS Provider Services Web Portal	Availity.com and select Claims & Payments > Claims Status Inquiry > Payer > MCS CA

Utilization Management (UM)

UM Intake	Telephone and Fax
Commercial HMO/PPO	800-274-7767 866-815-0839 (Fax)
CalPERS membership only	800-451-6780 866-815-0839 (Fax)
Specialty Drug Pre-Service Medical Review Program	800-274-7767 866-408-7195 (Fax)
Note: Drug list and pre-service medical review request forms are located online at anthem.com/ca. When faxing requests, Anthem Blue Cross pre-service medical review request forms are required. No other pre-service review request form will be accepted. Hours of Operation: 7:30 a.m. to 5 p.m. PST	

Utilization Management: Federal Employee Program (FEP)

The UM Program for the FEP is managed by Anthem Blue Cross and by Blue Shield of California, two separate and independent health plans. Each managed care health plan is responsible for specific Utilization Management programs, as follows:

Call Anthem Blue Cross for Retrospective Review of Institutional claims at 800-322-7319.

Hospice is part of Case Management and can be reached by telephone at 800-995-2800.

Home Health Care and Home Infusion Therapy billed by an Institutional Provider does not require authorization, unless the visits are used and then Case Management can be requested for additional visits. If a Professional Provider is billing for this care, they would contact Blue Shield of California at 800-824-8839.

Preadmission and Concurrent Review for an Institutional Provider is performed by Blue Shield. The telephone number is 800-633-4581.

Anthem Blue Cross FEP UM Programs		Telephone Number
Hospice Care	Case Management	800-995-2800

BlueShield of California FEP UM Programs		Telephone Number
Preadmission Review for Facility	Concurrent Review for Facility	800-633-4581

Website Address

The Anthem Blue Cross website is anthem.com/ca, select Menu > Support > *Providers*; features ProviderAccess®, pharmacy Formulary information, medical policy, Provider forms and much more. For Medicare Advantage information, please 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 Covered Individuals 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 under your ProviderAccess site in the 'Network Leasing' link. See page 16 for instructions regarding ProviderAccess login. Please refer to the Workers' Compensation section of this Manual for additional information regarding Medical Provider Networks and participation in the Anthem Workers' Compensation Network.

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

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Introduction

Anthem Blue Cross has networks of various types of participating Providers. This section provides a brief discussion of the Provider responsibilities as part of an Anthem Blue Cross network. Anthem Blue Cross Covered Individual must be referred to participating Providers to receive the maximum benefits available under the Agreement with Anthem Blue Cross.

For information on, or for a copy of, the *Directory of Participating Providers*, call the Customer Service telephone number listed on the Covered Individual's ID card. The Anthem Blue Cross website at anthem.com/ca includes a "Provider Finder" feature that can be used to locate participating Providers in a Covered Individual's area. The website for the Federal Employee Plan (FEP) PPO Covered Individual's professional Provider network is www.fepblue.org.

Anthem Blue Cross Access Standards

Anthem Blue Cross endorses and promotes uniform access standards for the health care delivery of preventive care appointments, routine primary care appointments, urgent care appointments, emergency care and access to after-hours care, behavioral health care and key elements of telephone service for Covered Individuals. Refer to the *Quality Improvement* section of this Manual for more information about access standards. For access standards regarding Workers' Compensation, please refer to the Workers' Compensation section of the Manual.

911/Emergency Care

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

If a Covered Individual considers a medical condition to be an emergency, he or she should be instructed to call 911 or go to the nearest hospital emergency room immediately. Anthem Blue Cross covers emergency services that are necessary to screen and stabilize a condition.

No authorization or precertification is needed if the Covered Individual reasonably believes that an emergency medical condition exists. An emergency room visit copayment may apply. Once the condition is stabilized, the Covered Individual or family of Covered Individual should contact his or her physician for authorization of any additional services. A Covered Individual should be directed to call the telephone number on his or her Anthem Blue Cross ID card with any questions.

A medical emergency is an unexpected acute illness, injury, or medical or psychiatric condition that could endanger health if not treated immediately.

Examples of medical emergencies include:

- Active labor
- Chest pains
- Severe pain

- Heavy bleeding
- Difficulty breathing or shortness of breath
- Sudden loss of consciousness
- Sudden weakness or numbness of the face, arm or leg on one side of the body
- Danger to self or others

California law requires health plans to follow the "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 draws on his or her practical experience when making a decision regarding whether emergency medical treatment is necessary.

Therefore, Anthem Blue Cross expects all participating Providers to instruct their after-hours answering service staff that, if the caller believes he or she is experiencing an emergency, the caller should be instructed to dial 911 or go directly to the emergency room.

If emergency service is authorized by the answering service, this authorization is considered binding and cannot be retracted at a later date. Answering machine instructions must also direct the Covered Individual to call 911 or go to the emergency room if the caller believes he or she is experiencing an emergency.

Participating Provider Responsibilities

Participating Providers are obligated to abide by responsibilities outlined in the Agreement, as well as those discussed in this Manual. Note: FEP PPO Member Covered Individuals, in order to maximize their benefits, must access the Blue Shield of California contracted Provider network.

Participating Provider responsibilities include, but are not limited to:

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

- Confirm that the person presenting the Anthem identification card is in fact the Covered Individual.
- Verify benefits and eligibility.
- Bill the appropriate health plan directly.
- The Provider is required to make best efforts to notify Anthem Blue Cross, in writing (at the below address), within 30 days, upon discovery that a Covered Individual may have additional insurance coverage.

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

  For FEP PPO Covered Individuals, please notify:

  Blue Shield of California
  P.O. Box 272510
  Chico, CA 95927

  Or by phone at 800-824-8839

- Participating Providers agree to admit or arrange for the admittance of Covered Individuals only to participating hospitals, unless admission to a nonparticipating hospital is either authorized in advance by Anthem Blue Cross for good cause or in case of emergency. See *Referrals to Nonparticipating Providers* in the subsection of this section.
- Participating Providers also agree to refer Covered Individuals to participating outpatient surgical centers (outpatient surgical centers, also known as ambulatory surgical centers, are independent medical facilities [not hospitals] where surgical procedures that do not require more than a 12-hour stay are performed) and other participating health care Providers in all circumstances, except when authorization to refer a Covered Individual to a nonparticipating surgical center or health care Provider has been granted in advance by Anthem Blue Cross, or when necessary due to an emergency.
- Failure to admit Covered Individuals to participating hospitals, mental health facilities or refer Covered Individuals to participating outpatient surgical centers and health care Providers in nonemergency situations without the approval of Anthem Blue Cross will be grounds for action by Anthem Blue Cross, including, but not limited to, termination from the Anthem Blue Cross Network.
- Cooperate with Anthem Blue Cross' Quality Improvement Program.
- The Provider must participate in Anthem Blue Cross' or other payor's Utilization Management (UM) program, and agree to cooperate with Anthem Blue Cross' administration of its internal quality-of-care review and grievance resolution procedures.
- Participating Providers must use their best efforts to prescribe generic drugs, as appropriate, and drugs contained in the *Anthem Blue Cross Outpatient Prescription Drug Formulary* to Covered Individuals. See the *Pharmacy Program and Guidelines* section of this Manual for further information.

- Allow Anthem Blue Cross access to medical records to the extent allowed by federal and state law.
- Maintain the confidentiality of Covered Individual information and records, and comply with Anthem Blue Cross' *Notice of Privacy Practices* and associated *Health Insurance Portability and Accountability Act* (HIPAA) standards.
- Openly communicate with patients about their treatment, regardless of benefit coverage limitations. It is Anthem Blue Cross' policy that UM decision-making is based only on appropriateness of care and service, and existence of coverage. The organization does not specifically reward Providers or other individuals for issuing denials of coverage or service. There are no financial incentives for UM decision-makers to encourage decisions that may result in underutilization.
- If a Covered Individual seeking medical services from a physician is identified as being in the first trimester of pregnancy, or is on the first visit for the condition, and if the pregnancy appears to be ongoing, the physician will refer the Covered Individual to the Anthem Blue Cross Future Moms program. The telephone number for enrollment in the Future Moms program is 866-664-5404. For more information about the Future Moms program and other health improvement resources, refer to the *360° Health®* section of this Manual. For FEP PPO Covered Individuals, Covered Individuals may call 800-828-5891.

Provider Data Management

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

For Ancillary, Facility and Professional Providers, and Behavioral Health Network:

- Send request to shared mailbox: ProviderDatabaseAnthem@anthem.com or fax them to: 818-234-2836.
- All changes must be submitted in writing via Request Form* or on letterhead, signed and dated by the participating Provider or management level staff (e.g. Owner, VP, CEO, etc.)
  - *Request Forms: The Behavioral Health, Facility and Professional Provider Forms are located on www.anthem.com/ca> Provider Home > Answers@Anthem > Provider Forms
- Include specific addresses, tax ID numbers, and telephone numbers for each location
- Submit practice changes within thirty (30) calendar days of change
- W-9 is required for tax ID change or tax ID name change; and Remit address changes; visit irs.gov to obtain a W-9 form

To add a Provider, a profile sheet needs to be included in the request

Misrouted Protected Health Information (PHI)

Providers are required to review all Member information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Members that a Provider is not currently

treating. PHI can be misrouted to Providers by mail, FAX, email, or FTP. Providers are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers permitted to misuse or re-disclose misrouted PHI. If Providers cannot destroy or safeguard misrouted PHI, Providers must contact Network Relations by email CAcontractsupport@anthem.com to report receipt of misrouted PHI.

Insurance Requirements

A. Providers shall, during the term of this Agreement, keep in force with insurers, having an A.M. Best rating of A minus or better, the following coverage:
   1. Professional liability/medical malpractice liability insurance, which 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 shall maintain coverage with limits of not less than the statutory cap.

      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, Providers agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.
   2. Workers' Compensation coverage with statutory limits and Employers Liability insurance.
   3. Commercial general liability insurance for Providers 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.

B. Self-Insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured Provider or Facility shall maintain and provide evidence 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. Designated professional liability or medical malpractice defense firm(s);
   4. Excess insurance/re-insurance above self-insured layer; self-insured retention and insurance combined must meet minimum limit requirements; and
   5. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.

C. Providers 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 request.

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements

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

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

In addition to the obligation to safeguard the privacy of any information that identifies a Covered Individual, 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 the Federal Exchange plans based on the health status of the Exchange Covered Individuals. Risk adjustment was implemented to pay health plans participating in Exchanges more accurately for the predicted health cost expenditures of Covered Individuals by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as an Exchange Participating Organization (EPO) defined by HHS, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that EPOs submit “all ICD-9 codes for each beneficiary,” Anthem also collects diagnosis data from the Covered Individuals’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the EPO is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician encounters only.

RADV Audits

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

ICD-9 CM Codes

HHS requires that physicians currently use the ICD-9 CM Codes (ICD-9 Codes) or successor codes and coding practices for Exchange product business. In all cases, the medical record documentation must support the ICD-9 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-9 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the Exchange participating organizations.

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.

Referrals to Nonparticipating Providers

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

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

1. The Provider is not participating with Anthem.
2. The Covered Individual may be responsible for extra costs if he/she receives services from that nonparticipating Provider.

3. The Covered Individual can call Anthem before getting services to confirm his/her benefits and can call to obtain the names of participating Providers that can provide the recommended services.
4. The nonparticipating Provider will collect copayments, deductibles, coinsurance or other amounts that the Covered Individual will be required to pay under his/her benefit plan.
5. The Covered Individual is voluntarily choosing to get services from this nonparticipating Provider.

Provider also agrees:

- If they refer a Covered Individual to a nonparticipating Provider, they will use their best efforts to require the nonparticipating Provider to abide by the terms of the Agreement.
- For Workers' Compensation, please refer to the *Workers' Compensation* section of this Manual.

Status of Participation in the Anthem Blue Cross PPO Network

Participating Provider responsibilities include but are not limited to:

- Providers agree to notify Anthem Blue Cross, in writing, of each separate tax identification number.
  - You may have several different tax ID numbers, but if you wish to be paid as a participating Provider or if you wish to avoid denials, you must notify Anthem Blue Cross to assure that your contract is updated appropriately.
- Maintain your credentialing, either as part of a delegated group or as an individual Provider. To find out more, go to the *Credentialing* section.
- Notify Anthem Blue Cross within 90 days of Provider (**including all specialists**) terminations, per your contract "Termination" provision, in order to allow Anthem Blue Cross to notify all Covered Individuals of any practitioner terminating that the Covered Individual has seen in the last rolling 12 months. Anthem Blue Cross will notify affected Covered Individual's dependent on the Provider's timely notification to Anthem Blue Cross. Covered Individuals with acute chronic conditions, or those who are pregnant, may be allowed to continue with the practitioner at in-network benefit levels. Affected Covered Individuals should be directed to call Anthem Blue Cross Customer Service for transition assistance. **Note: Behavioral Health Providers review your Agreement for timeframes.**
- Physician agrees to provide Covered Medical Services to any and all Covered Individuals until such time as Provider closes his/her practice and is no longer accepting new patients from any health plan with whom Provider contracts. Provider shall give Anthem Blue Cross prompt written notice of such practice closure.
- Providers must disclose to Anthem Blue Cross any interest in, affiliation with, or control they or their immediate family members have in another health care professional when referring patients for medical, health or administrative services to that health care professional (including, but not limited to: pathology, radiology, imaging and surgery centers). The Provider agrees to disclose information, on request, that includes, but is not necessarily limited to: the Provider's or

the Provider's immediate family member's percentage of control, ownership or other interest in such medical, health or administrative Provider. If no ownership or control exists, an explanation of the existence and nature of any Agreement for referrals between the participating Provider and said health care professional must be provided to Anthem Blue Cross. For Workers' Compensation Covered Individuals, please see the *Workers' Compensation* section of the Manual. This section will specify regulatory requirements to ensure you are in compliance.

Anthem Blue Cross must be notified of any legal, ethical or other actions against Providers or their license; any change in professional liability insurance premiums as a result of malpractice suits; or any change in hospital privileges (reduction, suspension or termination). Such actions include, but are not limited to, actions by the applicable state regulatory board, professional associations or hospitals. Providers authorize Anthem Blue Cross to receive reports, on demand, from state licensure agencies, professional associations and other organizations that maintain data relating to legal status, litigation and clinical performance history.

Participating Providers agree to maintain hospital privileges appropriate to their specialty at a participating hospital, unless Anthem Blue Cross agrees otherwise (in advance and in writing). Exceptions for appropriate specialty practices may be granted. Note: Not applicable to behavioral health Providers unless practicing in a hospital setting.

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

Other Payors

On initial signing of the Agreement, and within 30 days of receiving a written request from a Provider, Anthem Blue Cross will disclose a summary of all other payors currently eligible to pay the negotiated rates under the Agreement as a result of their arrangement with Anthem Blue Cross.

An alphabetic listing of these payors can be accessed via the ProviderAccess® website at https://provider2.anthem.com/wps/portal/ebpmybcc. To view this listing, from the ProviderAccess home page under the heading "News & Information," choose "Network Leasing Arrangements."

When the Anthem Blue Cross network is used by another payor, the Provider agrees to provide medical services to covered persons of that other payor.

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

California law (CA Health and Safety Code 1379) prohibits a Provider from seeking such payment from covered persons for sums owed by a Knox-Keene health care service plan. If Anthem Blue Cross contracts with another Knox-Keene-licensed health care service plan to permit access to the Anthem Blue Cross network, Anthem Blue Cross will notify all affected participating Providers in the service area

by mail and identify such health care service plan.

When another payor uses the Anthem Blue Cross network, Provider will follow such other payor's utilization review requirements regarding the determination of Medical Necessity and appropriateness of services provided, as well as other designated requirements.

Workers' Compensation

In the event a Covered Individual seeks services for a work-related illness or injury and is covered for Workers' Compensation benefits by a Workers' Compensation Other Payor affiliated with Anthem Blue Cross, the Provider agrees to provide medically necessary services, and complete a Provider's first report of services, unless the Provider has elected to opt-out of the Workers' Compensation program participation in accordance with their Anthem Blue Cross Agreement and as defined in California Labor Code section 4609.5.

The Provider will receive compensation in accordance with the schedule contained in the payment schedule of the Agreement. If the Covered Individual requires additional treatment beyond that provided at the first visit, the Provider agrees to refer the Covered Individual only to a participating Provider in the Anthem Blue Cross network.

If the Provider elects not to treat the Covered Individual for a work-related illness or injury, he or she agrees to refer the Covered Individual to a participating Provider in the Anthem Blue Cross Worker's Compensation network or the other payor's Medical Provider network. Refer to the *Worker's Compensation* section.

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 Blue Cross.

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 UB04 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)

This information can also be found in the *Claims Submission* section. If you have additional questions regarding electronic claims submission contact your local EDI department at 1-800-470-9630. For paper claims contact the Provider Care department at 800-677-6669.

Guaranteed Payment to Providers

Effective January 1, 2008, California law (CA Health & Safety Code 1371.8) requires a Health Plan that authorizes specific treatment for a Covered Individual with a Health Benefit Plan regulated by the Department of Managed Health Care to not rescind or modify this authorization after the Provider renders the treatment in good faith and pursuant to the authorization. Anthem Blue Cross' authorization process complies with this law, so that if Anthem Blue Cross authorizes services under the Case Management/Utilization Review Programs for a Covered Individual regulated by the Department of Managed Health Care, Anthem Blue Cross will not rescind or modify such authorization when the Provider has already rendered services in good faith.

Health Care Providers' Bill of Rights

Health Care Providers' Bill of Rights (CA Health & Safety Code 1375.7) prohibits provisions in a contract between health care service plan or health insurer and a health care practitioner that would allow the plan or insurer to unilaterally change a material term of the contract without meeting specified requirements.

As a result, Anthem Blue Cross will give its participating Providers at least 90 days prior written notice of any change to a material term in the Agreement or this Manual except changes necessary to comply with state and federal laws or any accreditation requirements.

Pursuant to such notice, Anthem allows a Participating Provider to terminate the Agreement as of the effective date of such change (except for the above described exclusions) upon prior written notice to Anthem Blue Cross no later than 45 business days after receipt of Anthem Blue Cross' notice, notwithstanding the provisions of the Agreement and such new material changes will not be applied to such terminating Participating Provider prior to their termination.

Continuity of Care/Transition of Care

Covered Individuals may, in certain circumstances, have the right to complete a course of otherwise covered treatment with their Provider at an in-network rate when that Provider has terminated from the Anthem Blue Cross network or if the Provider does not participate in the Anthem Blue Cross network for

a newly covered enrollee. For more information, refer to the *Medical Management Programs* section of this Manual.

Health care service plans (other than a specialized health care service plan offering mental health services on employer-sponsored group basis) are required to establish written continuity-of-care policies describing any procedures followed by the plan.

For FEP PPO Covered Individuals, please contact the customer service number on the back of the Covered Individual's ID card for Care Coordination. Callers will be directed to a nurse who will focus on the individual health care needs, and coordinate the care they may need.

Coordination of Care

Anthem Blue Cross 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 Blue Cross Covered Individuals. Please discuss the importance of this communication with each Covered Individual and make every reasonable attempt to elicit his or her 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. You may ask the Covered Individual to sign the Patient Consent to Exchange Information Form prior to any communication. A copy may be sent to the Covered Individual's PCP or psychiatrist and retained in the Covered Individual's file. The form is not required to be completed by the Covered Individual. If the Covered Individual declines, his or her decision should be documented in the Covered Individual's medical record.

Patient Consent to Exchange Information Form Availability

Although this form is offered by Anthem Blue Cross and not required, you may decide to use it for all Covered Individuals (patients). A copy of the Patient Consent to Exchange Information Form is available at anthem.com/ca.

Note: This does not include psychotherapy notes.

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 Covered Individual 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 bill also required all Plans to have a

Language Assistance Plan (LAP) for Covered Individuals who are considered to be Limited English Proficient (LEP) when a threshold number of these individuals is reached using the total Covered Individuals 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 Blue Cross 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 Covered Individuals. In addition, insurers licensed by the CDI were required to comply with similar regulations effective April 1, 2009.

At Anthem Blue Cross, we believe in the strength and value of cultural diversity. We realize that communication with physicians and other Providers of health care services is paramount to ensuring optimum health and wellness. To facilitate communication, we offer interpretation services to eligible Covered Individuals at no cost. In addition, translated documents are provided to Covered Individuals in the languages required by the language assistance regulations.

Objectives of the Language Assistance Program

- Identify the cultural diversity of our Covered Individuals.
- Explain what is meant by sensitivity to cultural differences.
- Describe the Language Assistance Program services available from Anthem Blue Cross.
- List guidelines for working effectively with LEP Covered Individuals.
- Provide essential tips for working effectively with telephonic interpreters.

I. Cultural Diversity

Anthem Blue Cross has used U.S. Census information and UCLA statistics to determine the five threshold preferred spoken and written languages for HMO and PPO Covered Individuals. (Threshold languages for plans with enrollment of 1,000,000 or more represent 0.75 percent of the plan's membership or 15,000 Covered Individuals, whichever is less.)

The threshold languages for Anthem Blue Cross and Anthem Blue Cross Life and Health Covered Individuals are:

- Spanish
- Chinese
- Vietnamese
- Korean
- Tagalog

Anthem Blue Cross' LAP is designed to meet the growing needs of California's diverse population. Anthem Blue Cross is responsible for continually identifying common or "threshold" languages preferred by our Covered Individuals; as well as identifying, tracking, and reporting the written and spoken language preference of each Covered Individual.

As a best practice, physicians and other health care professionals are encouraged to document a Covered Individual's preferred spoken and written language in their office chart or medical record.

II. Cultural Sensitivity

Recognizing that language is not the only aspect of cultural diversity affecting health care communication, Anthem Blue Cross offers access to information for physicians and other health care professionals that addresses cultural sensitivity and cultural differences, including:

- Communication Styles
- Health care Traditions
- Commonly Held Beliefs
- Alternative Medicine and Healing
- Disparities (Including Quality of Care and Preventive Care)
- Pain Management and Treatment
- Aging

As an incentive to explore this important information, Anthem Blue Cross provides Continuing Medical Education (CME) opportunities relative to cultural sensitivity and cultural differences at anthem.com/ca.

- Under the "INFORMATION FOR" menu on the right side of the screen, click on the "Providers" link.
- From the newly opened window, click the "Enter" button.
- Select "Health & Wellness" from the menu bar at the top of the page.
- From the Health & Wellness page, click on "Cultural and Linguistic Provider Resources."
- From the "Cultural and Linguistic Provider Resource" page, click on the "Training: Cultural and Linguistic CME Courses" link.

As a best practice, Anthem Blue Cross encourages physicians and other health care professionals to enhance their knowledge and appreciation of the many cultural differences that are inherent in their region by enrolling in and completing these online courses.

III. Anthem Blue Cross Language Assistance Program

The following services are offered at no cost to Covered Individuals:

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 HIPAA and ethical standards. Points of contact include administrative, health care, and related services. Anthem Blue Cross' interpretation vendors are contracted to have professional

interpreters available in all languages within 10 minutes upon request. To assist a Covered Individual in accessing an interpreter during regular business hours, physicians and other health care professionals are instructed to have their Anthem Blue Cross patient call the Customer Service telephone number located on his or her Covered Individual ID card and request the service. Alternatively, physicians and other health care professionals may call Anthem Blue Cross' Provider Care at 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.

Written materials are provided in five threshold languages: Spanish, Chinese, Vietnamese, Korean and Tagalog. Materials translated prospectively include enrollment, eligibility and Covered Individual information, Explanation of Benefits (EOB), and notices of language assistance. Covered Individuals indicate their preferred written language to receive prospectively translated materials.

Written materials are translated into a threshold language upon request. Materials that are Covered Individual-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 Covered Individual 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 by calling 888-254-2721 to request translated materials. Alternately, physicians and other health care professionals can call Anthem Blue Cross at 800-677-6669 to request translation on the Covered Individual's behalf. Urgent requests are handled within one business day and non-urgent requests are handled within two business days. A copy of the document is required in order to complete the translation request.

Oral translations are provided for all languages. 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.

TTD TTY services for deaf, hard of hearing or speech impaired Covered Individuals.

Approved Industry Collaboration Effort Documents are available at:
http://www.iceforhealth.org/library.asp?sf=&sc=APPROVED+ICE+DOCUMENTS

IV. Working Effectively With LEP Covered Individuals

For successful interactions between physicians and other health care professionals, and LEP Covered Individuals, it is important to:

- Notify LEP Covered Individuals of the services available.
- If the LEP Covered Individual does not request interpreter services, please offer the service during the health care visit or contact.
- If a Covered Individual has not notified Anthem Blue Cross of their preferred spoken or written language, they are still entitled to language assistance services.
- If a Covered Individual brings a family member or friend to their health care visit and requests to use such family member or friend as an interpreter, please offer the use of a professional interpreter. If the Covered Individual refuses the offer of the professional

interpreter, the offer of a professional interpreter and the Covered Individual's decision to use the family member or friend as the interpreter must be documented in the patient record. Anthem Blue Cross 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 Covered Individual is fully informed in their primary/preferred spoken language that a qualified interpreter is available at no charge to them. If the Covered Individual refuses the offer of the qualified interpreter, the offer of a qualified interpreter and the Covered Individual'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 Covered Individual 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.

V. 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 Covered Individual 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 Covered Individual, 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 Covered Individual's language.
- Avoid medical jargon or technical explanations unless they are requested by the Covered Individual.
- Avoid interrupting the interpreter.

If the Covered Individual's non-verbal cues indicate confusion, ask the Covered Individual to summarize or restate what has been communicated.

VI. Information Available on Department of Managed Health Care Website

Informational notices explaining how Covered Individuals 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. 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:

Department of Managed Health Care
Attention: HMO Help Notices
980 9th Street, Suite 500
Sacramento, CA 95814

We sincerely hope that this information is useful in your everyday encounters with LEP Covered Individuals. Contact Anthem Provider Services at 800-677-6669 if you have any questions or require assistance with the LAP.

For FEP PPO:

To access the Language Assistance Program for professional Providers, please call 800-874-9426.

Covered Individuals with FEP can call 800-284-9093.

Covered Individual Rights and Responsibilities Statement

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Covered Individuals, their Providers and Facilities and their health care benefit plans. One of the first steps is for Covered Individuals, Providers and Facilities, to understand member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to anthem.com. Select the "Provider" link at the top of the landing page (under the "Other Anthem Websites" section). Select your state from the drop down list, and click "enter." Select the Health & Wellness tab, then the link titled "Quality Improvement and Standards." If Covered Individuals need more information or would like to contact us, they are instructed to go to anthem.com and select "Customer Support," then "Contact Us." Or they can call the Member Services number on their ID card.

Health Insurance Portability and Accountability Act

The *Health Insurance Portability and Accountability Act* (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 Anthem Blue Cross' *Notice of Privacy Practices* and updates regarding HIPAA, including key articles in *Professional Network Update* and the *Behavioral Health Network Update,* refer to the Provider web portal, at anthem.com/ca, and select "Privacy statement" at the bottom of the landing page.

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

The *California Confidentiality of Medical Information Act* also requires that a person or entity seeking to obtain medical information must receive authorization from the patient, except where allowed by the Act.[1]

The Act further prohibits plan contractors, corporations, or their subsidiaries and affiliates from intentionally sharing, selling or using medical information for any purpose not necessary for the provision of health care services to the Covered Individual.

California's Health Care Decisions Law (Advance Health Care Directive)

California's advance directive laws make it easier for individuals to make their preferences known in advance, through written and oral communication, in case they are incapacitated and unable to verbalize medical requests. To obtain a copy of the law, visit www.leginfo.ca.gov

[1] See California Civil Code 56.10 (b) and (c) for exceptions.

Advance Health Care Directive Forms

- The California Hospital Association's Free resources Forms and Handouts section contains a copy of a suggested form in both English and Spanish. Manuals can be ordered by calling 916-443-7401, or by visiting www.calhospital.org
- The California Medical Association (CMA) has developed an *Advance Health Care Directive Kit*, which includes a new form. To order, call CMA Publications at 800-882-1CMA or visit www.cmanet.org under the Professional Resources, Resources Library and Store Section.
- Caring Connections has state-specific forms that can be downloaded from its website at www.caringinfo.org.

ProviderAccess® and the Availity Web Portal (Availity)

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Introduction

Availity is the Web portal for Anthem Blue Cross eligibility, benefits and claim status inquiry functionality. All Participating Providers MUST register for Availity to access these functions and more 'value-add' features and services.

ProviderAccess®, Anthem Blue Cross' Provider Web portal, is available to contracting health care Providers. This site includes News & Information, Provider Manuals, Policies and Procedures, and Provider Forms. It also includes claims reporting, Remittance Advice Inquiry, Clear Claim Connection and much more. All Participating Providers MUST register for ProviderAccess to also access these functions.

ProviderAccess® and Availity will minimize time spent on the telephone with Customer Service and allow more time for you to spend with your patients. In fact, it may eliminate 80 percent of routine inquiries to Anthem Blue Cross.

Both Web portals are 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.

This section provides important facts and features about secure Web portal access for Anthem Blue Cross.

Availity Web Portal (Availity)

! IMPORTANT NOTE: Availity replaced ProviderAccess' eligibility and benefit and claim status inquiry functions. If you haven't already, you should log on to availity.com and get registered.

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 benefits patients, Providers and health plans!

Get the information you need instantly

You can access real-time eligibility and benefits, claims status information and much more through one secure web portal 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 claim 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 pre-certification requests and inquiries through AIM.

- Member Certificate Booklet – view a local plan Member's evidence 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. Click "Register Now."
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, please contact Availity Client Services at: 800-282-4548.

Is Training Available?

Of course! Once you have registered to become an Availity user, simply log in to the web portal and click on Free Training from the top navigation bar. 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.

Interested in learning more about Availity? Attend a FREE workshop in your area, click this link: rsvpbook.com/AvailityWest

ProviderAccess® Portal

ProviderAccess®, Anthem Blue Cross' Provider web portal, is still available exclusively to contracting health care Providers for proprietary information including: News & Information, Provider Manuals, Policies and Procedures and Provider Forms. ProviderAccess enables health care professionals to perform a seamless and secure timesaving transaction online. It also provides business resources, remittances, and reports for local and out-of-area BlueCard® Covered Individuals.

This site includes News & Information, Provider Manuals, Policies and Procedures, and Provider Forms. It also includes claims reporting, Remittance Advice Inquiry, Clear Claim Connection and much more.

Overview Tab

- News and Information – EDI Services, Provider Contact List, Network Leasing Arrangements (TPA, ASO, etc.), BlueCard Claims Advisor
- What's New – new information, functions, features and the Fee Schedules including Behavioral Health
- Provider Manuals
- Policies and Procedures – Medical Policies and Clinical UM Guidelines Global Pricing and Claims Edits Policy, Behavioral Health Clinical UM Guidelines, ASC Grouper List (Freestanding Ambulatory Surgery Centers)
- Updates – Medicaid Business Fee Schedule
- Provider Forms – Provider Dispute Resolution Request, Provider Change Form, etc.

Claims

- Obtain reports, which can be sorted by received, processed or pending.
- View the Claims Overpayment Report.
- Initiate a Remittance Advice (RA) inquiry for a Professional EOB or an Institutional RA.
- BlueCard Advisor allows you to verify which health plan the claim should be sent to prior to submitting the claim.
- Clear Claim Connection – is intended as a tool for evaluating clinical coding information and is not a guarantee of a Member eligibility or claim payment. Clear Claim Connection will provide information according to the claim editing system logic in place on the date of the Provider's inquiry.

Reports

- View HMO eligibility and capitation reports.
- View Medicaid eligibility and capitation reports.
- View Noncapitated Service Paid Claims reports.
- View Utilization Rates and Unit Cost Reports.

How do we get registered for ProviderAccess?

1. Go to anthem.com/ca
2. Click 'Register Now' under ProviderAccess Login
3. For support with registration, Account Administrator changes, technical support, password resets or issues re-accessing the web portal; contact us at:
   - Telephone Number: 866-755-2680, Monday through Friday, 5 a.m. to 5 p.m. PST.
   - Email: provideraccess.pins@wellpoint.com

AIM Specialty Health (AIM®)

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 clicking 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

Click on "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 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

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

Once on 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, please log on to ProviderAccess, click on 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.

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Coverage for Behavioral Health Services Under Mental Health Parity Legislation 8

Introduction

There is a wide variety of criteria used to determine who is eligible for benefits, as well as when a Covered Individual's begins and terminates. The scope and complexity of these criteria make a listing of them infeasible for this Manual. In this section, Anthem Blue Cross discusses the options available for verifying eligibility, including ID cards, online inquiry using Availity®, and Interactive Voice Response (IVR).

! Note: Eligibility for BlueCard® Covered Individuals may not be determined through the use of Availity or the IVR. How to determine the eligibility of BlueCard Covered Individuals is addressed within the respective subsections below,

Identification (ID) Cards

All Covered Individuals are issued an ID card in either paper or plastic, depending on which type of card the employer group chooses. The Covered Individual should carry his or her ID card at all times and present it when seeking medical services.

ID cards generally provide the following information:

1. Subscriber, spouse, domestic partner or covered dependent name
2. Certificate number
3. Employer group number (for group coverage only)
4. Anthem Blue Cross plan code
5. Coverage code
6. Medical group name, address and phone number (if HMO or POS)
7. Subscriber's effective date with the medical group (if HMO or POS)
8. Additional benefits rider (where applicable)
9. Claims mailing address(es) and Customer Service telephone number(s) for the medical program and any supplemental benefits
10. Instructions regarding carrying and using the ID card
11. Guidelines for obtaining services and reporting emergencies (if HMO or POS)
12. Telephone number for preauthorization or pre-service review (if PPO); this information is not available on the Medicare Advantage ID card

Refer to the *Exhibits* section of this Manual for additional samples of Anthem Blue Cross ID cards.

- BlueCross BlueShield Federal Employee Program
- Medicare Preferred
- Blue Cross POS
- Blue Cross PPO
- Blue Cross Select PPO

No standard temporary ID card exists, though some groups may distribute customized temporary ID cards to group Members. The information on the cards varies depending on each specific group's requirements.

Customized Identification (ID) Cards

Anthem Blue Cross has several customized ID cards that do not feature the Anthem Blue Cross logo or any Anthem Blue Cross affiliate's logo. Because of contracting arrangements with some Large Group employer groups, the employer's logo appears on the ID card. To identify Anthem Blue Cross PPO Covered Individuals with these ID cards, pay special attention to the product name on the card.

Web-Based Temporary Identification (ID) Cards

Covered Individuals who have not yet received their permanent ID cards can now print temporary ID cards online through our website, at anthem.com/ca, and present them when seeking health care. New Covered Individuals seeking medical attention should be asked for their temporary ID card to verify that the Covered Individual is seeking care at his or her chosen medical group. These temporary ID cards are not meant to replace the permanent ID cards and will expire 30 days after the issue date. Covered Individuals will still receive a permanent ID card.

The temporary ID card works in tandem with our First Impressions program for Covered Individuals that are not yet loaded onto our eligibility system.

The temporary ID card includes the following elements:

1. Customer Service phone number
2. Claims address
3. Medical plan
4. Medical group office name and telephone number, if applicable
5. Primary care physician (PCP) name and telephone number, if applicable

Note: The temporary ID card does not include the copayment amount or other benefit information. The card instructs Providers to call Anthem Blue Cross and verify eligibility and benefits.

Online Inquiry via Availity

Availity Web Portal (Availity) is the website available **free of charge** to participating Providers. Availity enables Providers to check Covered Individual's benefits, eligibility, and deductible and claims status online.

Through Availity detailed information can be queried on an unlimited number of Covered Individuals. The site allows users to spend less time on the telephone and devote more time to other important tasks.

The information on the Availity Web Portal is updated in real time – the same information Providers would obtain if Customer Service was called.

For more detailed information on how to access eligibility information online, refer to the *ProviderAccess® and the Availity Web Portal* section of this Manual.

Interactive Voice Response (IVR) System

Interactive Voice Response (IVR) is an automated computer system that provides real-time information on the most current eligibility data for most Anthem Blue Cross non-Federal Employee Program (FEP) Covered Individuals.

To access the IVR, use the Customer Service telephone number on the Covered Individual's ID card. If that information is not available, use one of the following telephone numbers:

Service Area	Telephone Number
Anthem Blue Cross Large Group Provider Information Service	800-677-6669
Anthem Blue Cross Small Group Customer Service	800-627-8797
Anthem Blue Cross Individual Customer Service	800-333-0912
The IVR is not available for verifying FEP eligibility. Providers should call FEP Customer Service line for assistance with FEP-related inquiries	800-824-8839

The IVR unit is available 24 hours a day, seven days a week.

Be sure to have your tax ID number and the nine-digit Member certificate number ready before dialing the appropriate IVR toll-free number.

BlueCard® Eligibility and Benefits

When a Blue Cross and/or Blue Shield (BCBS) Covered Individual from an out-of-area plan is present at your office or Facility, request their ID card for each visit. Benefits and status can change, and, as a result, a Covered Individual may receive a new ID card. The two main identifiers on the ID card are the alpha prefix and, for eligible PPO Covered Individuals, a "PPO in a suitcase" logo.

The three-letter alpha prefix of the ID number is the key element used to identify and correctly route out-of-area claims. It identifies the Covered Individual's plan or whether the Covered Individual is covered by Negotiated National Account Arrangements (which include National Account models other than the BlueCard® Program such as ITS Custom arrangements, Custom Network arrangements and NASCO Plan to NASCO Plan arrangements) and Medicare Supplemental/Medigap/Medicare Complementary arrangements, as applicable.

Some ID cards may not have an alpha prefix. This indicates that the claims are handled outside the BlueCard Program.

ID cards from International BCBS Covered Individuals will also contain three-character alpha prefixes and may or may not have a benefit product logo.

Blue Cross and Blue Shield PPO Covered Individuals can be recognized by the special "PPO in a suitcase" logo on their ID cards. BlueCard PPO Members are BCBS Members whose PPO benefits are delivered through the BlueCard Program. **It is important to remember that not all PPO Covered Individuals are BlueCard PPO, only those Covered Individuals with a "PPO in a suitcase" logo on their ID cards are BlueCard PPO.**

BlueCard POS Covered Individuals can be recognized by the empty suitcase in the top right-hand corner of the ID card, as well as the Anthem Blue Cross POS logo.

Covered Individuals traveling or living outside of their plan's service area receive the PPO level of benefits when they obtain services from designated PPO Providers.

BlueCard PPO Covered Individuals receive information about participating BlueCard PPO Providers through a national toll-free number and website that allows Anthem Blue Cross to direct patients to you. Providers can also use this number to find information on PPO Providers in another plan's service area. The number is 800-810-BLUE or 800-810-2583, and the website is www.bcbs.com. If you are not sure whether you are a BlueCard PPO Provider, contact Anthem Blue Cross.

After obtaining the Covered Individual's ID card, verify the coverage information by calling 800-810-BLUE or 800-810-2583. The system will prompt you to key in the alpha prefix on the ID card by converting the alpha characters to numerals. You are then routed to the appropriate unit at the Covered Individual's BCBS plan. If you are unable to locate an alpha prefix on the Covered Individual's ID card, check for a telephone number. If that is not available, call Anthem Blue Cross at 800-444-2726 to speak to one of our dedicated BlueCard customer service representatives. For information on BlueCard claims, see the *Claims Submission* section of this Manual.

! For more information about BlueCard® click on this link, BlueCard® Program Provider Manual to be taken directly to our anthem.com/ca website.

Newborns

Newborn services, including newborn hospital care, periodic checkups and immunizations, are covered for the first 31 days of life. After 31 days, services are provided only if the newborn is properly enrolled. 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 in the medical group of their choosing. If the newborn remains in the hospital, the newborn should be added to the same medical group as the mother, until discharged home. If the newborn remained in the hospital after the mother was discharged, but the newborn is now home, the newborn may be enrolled in a different medical group effective the date that the newborn was discharged home 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 Covered Individual's or insured person's EOC or certificate.

If you have any questions regarding whether this coverage is applicable to a specific employer group, call the Customer Service telephone number on the back of the Covered Individual's ID card.

Rescission Investigation – Providing Medical Records

Anthem Blue Cross Covered Individuals who have an Individual (non-group) contract must disclose all material medical information at the time of initial underwriting. Within the first two years of the Individual's effective date, material medical information that was intentionally misstated on, or omitted from, the Covered Individual's application will be reviewed by Anthem Blue Cross' Medical Investigations Unit. This medical information, along with any additional medical or other information, will be compared to the medical history disclosed on the Covered Individual's application. (Not applicable for Medicare Advantage Covered Individuals.)

Note: If during the first two years of coverage, Anthem Blue Cross discovers that a Covered Individual performed or engaged in any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact that was not disclosed on the application, Anthem Blue Cross may rescind the individual's coverage as if it never existed back to the original effective date. Additionally, if within two years after adding additional dependents (excluding newborn children of the insured added within 31 days after birth), Anthem Blue Cross discovers the Covered Individual seeking coverage for any additional dependents performed or engaged in any act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact, Anthem Blue Cross may rescind coverage for the additional dependent as of the date he or she originally became effective.

Requests for medical information from an Anthem Blue Cross PPO Provider will be specific and may require all office records including, but not limited to, office progress notes, lab reports and consultation reports up to five years prior to the Covered Individual's Anthem Blue Cross effective date.

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

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

Verify Benefits and Eligibility for Behavioral Health Care Services, Including ABA

Prior to initiating treatment with a Covered Individual, call the Customer Service number identified on the ID card to determine benefits, eligibility and utilization review requirements. In most cases, Anthem Blue Cross Covered Individuals have direct access to behavioral health services; however, a Covered Individual's plan may require a pre-service authorization and/or concurrent review for outpatient services by Anthem Blue Cross. When calling, document the number called, the information given and the name of the Customer Service Representative spoken with for your records. Photocopy the ID card (front and back) and keep it in their file for future reference.

Participating Providers should also remember to request a new copy of the Covered Individual's ID card and verify benefits at the beginning of each calendar year in the event a Covered Individual's plan has changed. We recommend participating practitioners verify benefits and eligibility periodically throughout the calendar year to confirm Member eligibility.

Contact the Customer Service Unit:

- Eligibility of coverage. Coverage can change throughout the calendar year.
- Benefits for behavioral health services, including ABA:
  - Copays and coinsurance
  - Deductible amounts (if applicable)
  - Maximum number of sessions per calendar year (if applicable)
  - California or Federal Mental Health Parity (MHP) benefits
  - TPAs (if applicable)
  - Pre-service or concurrent review requirements
  - NOTE: ABA services require preauthorization. Contact Behavioral Health UM at 800-399-2421 for preauthorization requirements before initiating treatment with Covered Individual.
- Behavioral Health not managed by Anthem Blue Cross. Covered Individuals may have Anthem Blue Cross medical coverage and a different carrier for behavioral health care services (i.e. TPA). Contact the other carrier for further information regarding benefits and eligibility.
- Utilization Review requirements (if applicable). Covered Individuals who have their coverage through a self-funded employer plan or a state-sponsored program may have a plan that requires some management of outpatient professional services. In addition, management of outpatient professional services is applicable to many Anthem Blue Cross self-funded PPO and HMO plans. This may include pre-service and concurrent review of outpatient care that may be required prior to initiation of treatment, or following 12 visits. Participating practitioners must call for pre-certification and concurrent review for Facility-based treatment. To determine which products require outpatient professional service review and whether the requirement is pre-service or after 12 visits, always call the Customer Service number on the Covered Individual's ID card prior to initiating treatment to verify benefits, eligibility and authorization requirements.
- Claims address. Anthem Blue Cross has a single mailing address for claims. Review the *Claims Submission* section for additional information.

Benefits for Covered Individuals will be different for those who are eligible for California Mental Health Parity or Federal Mental Health Parity benefits, or not eligible for any MHP benefit. See Coverage for Behavioral Health Services under Mental Health Parity Legislation in this section for additional information.

In Third Party Administrator or Payor (TPA) situations, call the TPA number specified on the Covered Individual's ID card. If Anthem Blue Cross is providing the company with a managed behavioral health program, please refer to the specific telephone numbers found in the *Directory of Services* section of this Manual.

Coverage for Behavioral Health Services Under Mental Health Parity Legislation

Anthem Blue Cross Covered Individuals in California may be eligible for benefits under the Federal Mental Health and Addiction Equity Act and/or the existing California Mental Health Parity Legislation. Practitioners should make sure to ask about this coverage whenever verifying benefits and eligibility.

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Introduction

This section provides general billing guidelines and claim submission requirements for Anthem Blue Cross. To assist the biller in reducing the number of returned claims, the Manual identifies the more common situations that result in returned or rejected claims and processing delays. Also covered is an overview of electronic billing and contact information for electronic data interchange (EDI) products and services.

Claim Editing and Reimbursement Policy Application

Anthem Blue Cross uses Member benefits, Health Plan reimbursement policies, and a claim editing software package from McKesson Corporation, called ClaimsXten®, in its adjudication of claims.

- ClaimsXten applies claim management rules in support of specific claim edits.
- These claim management rules are applied to Current Procedural Terminology (CPT®) and Healthcare Common Procedure Coding System (HCPCS), and International Classification of Diseases, 9th Revision, Clinical Modifications (ICD-9-CM) codes on a *CMS-1500 Claim Form*. The claim management rules assess the relationship of such codes to the rules.
- The editing logic for the rules considers AMA/CPT and national specialty society publications, The Centers for Medicare & Medicaid Services (CMS) coding guidelines, input from McKesson physician consultants and the Health Plan's guidelines.
- The edit(s) that is/are associated with a claim management rule causes an audit action on a claim that directs how procedure codes and procedure code combinations will be adjudicated.
- The edits associated with the ClaimsXten claim management rules identify, for example and without limitation: age and gender specific procedures; duplicate codes; incidental procedures; unbundled/rebundled procedures; mutually exclusive and/or redundant procedures; place, time and type of service; incorrect coding of specific codes; service utilization, such as the administration of anesthesia and/or use of an assistant surgeon; and services integrally related to a surgery (global surgery). A list of ClaimsXten management rules that have been adopted may be located using your secure log on to the Anthem Provider website at anthem.com/ca/home-providers.html
- The rules and edits associated with the ClaimsXten claim management rules are updated quarterly and information on changes will be posted to the Anthem Provider website and in some instances a separate letter outlining the changes, when significant, will be mailed to all impacted Providers. Copies of these notifications are also posted to the website.
- ClaimsXten also provides the editing tools to incorporate the administration of Anthem Blue Cross' reimbursement policies. Information on these policies is located using your secure log on to the Anthem Provider website at anthem.com/ca/home-providers.html

Clear Claim Connection

Clear Claim Connection is a web-based tool that enables Providers to review the claim auditing rules and clinical rationale inherent in the ClaimsXten Processing software. Providers will be able to access the Clear Claim Connection through the Anthem Blue Cross website in order to be able to:

- Prospectively prescreen claims.
- Retrospectively inquire on claim disposition.

Use of Social Security Numbers

Background

California regulates the usage and disclosure of individual Social Security Numbers (SSNs). It is intended to provide additional protection against identity theft by limiting the use of an individual's SSN.

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

The intent of the law is to protect California residents. Consequently, all persons or entities that communicate with California residents by U.S. mail or via the Internet, and use or disclose these individuals' SSNs, may need to comply with the law by the relevant effective dates for their California contacts.

The law does not apply to individuals who travel to California, but reside in another state.

The law does not prevent the collection, use or retention of SSNs as required by state or federal law, or the use of SSNs for internal verification or administrative purposes, as long as the use does not result in the public display or disclosure of the SSN.

Restrictions

Persons or entities are prohibited from engaging in the following activities:

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

Claims Settlement Practices

The California Department of Managed Health Care (DMHC) has set forth regulations establishing certain claim settlement practices and the process for resolving Provider disputes for managed care products. The following notice 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 Blue Cross 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.* FEP is not within the jurisdiction of the DMHC. FEP is governed by Federal regulations.

Information for Contracting Providers

Claim Submission Instructions [excluding Blue Distinction Centers of Transplant (BDCT) and Centers of Medical Excellence (CME) contracted Providers]. Please refer to the BDCT reference manual or CME Operations manual for submission instructions.

1. **Sending Claims to Anthem Blue Cross.** Send all hard copy claims to:

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

   FEP
   Blue Shield of California
   P.O. Box 272510
   Chico, CA 95927

2. **Calling Anthem Blue Cross Regarding Claims.** See the *Directory of Services* section, under "Claims and Correspondence Mailing Addresses," for a list of telephone numbers by "Type of Plan" or follow the instructions on the back of the Covered Individual's ID card.
3. **Claim Submission Requirements.** A list of commonly required claim attachments, supporting information and documentation required by Anthem Blue Cross may be found in this Manual.
4. **Claim Receipt Verification.** To verify receipt of your claim, log in to Availity® at **availity.com**. For more information on Availity see Section titled *Provider Access and the Availity Web Portal (Availity)* you may also contact us by plan type at the customer service telephone number listed on the back of the Member's ID card. Your Explanation of Benefits (EOB) or Remittance Advice (RA) will verify receipt of your claim, as well.
5. **Blue Shield Customer Service** (FEP Professional Services): 800-824-8839

Non-Member Transplant Donor Claim

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

Claim Overpayments

1. **Notice of Overpayment of a Claim.** If Anthem Blue Cross determines that it has overpaid a claim, Anthem Blue Cross will notify the Provider, in writing, through a separate notice identifying the claim, the name of the Member, the date of service(s) and the overpayment reason on which Anthem Blue Cross believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim.
2. **Blue Shield (for FEP Covered Individuals) processes their overpayments for professional Providers:** 800-824-8839

3. Contested Notice. If the Provider contests Anthem Blue Cross' notice of overpayment of a claim, the Provider, within 30 working days of receipt of the notice of overpayment of a claim, must send written notice to Anthem Blue Cross stating the basis on which the Provider believes that the claim was not overpaid. Anthem Blue Cross will process the contested notice in accordance with Anthem Blue Cross' contracted Provider dispute resolution process, as described in the *Dispute Resolution Process for Contracted Providers* section of this Manual.
4. No Contest. If the Provider does not contest Anthem Blue Cross' notice of overpayment of a claim, the Provider must reimburse Anthem Blue Cross within 30 working days of the Provider's receipt of the notice of claim overpayment.
5. Offsets to Payments. If the Provider does not reimburse Anthem Blue Cross within 30 working days of the Provider's receipt of the notice of overpayment of a claim, then, pursuant to the Agreement, the Provider authorizes Anthem Blue Cross to offset an uncontested notice of overpayment of a claim from the Provider's current claim submission. Anthem Blue Cross may only offset an uncontested notice of overpayment of a claim against a Provider's current claim submission when: (i) the Provider fails to reimburse Anthem Blue Cross within the timeframe set forth in No Contest, above, and (ii) Anthem Blue Cross' contract with the Provider specifically authorizes Anthem Blue Cross to offset an uncontested notice of overpayment of a claim from the Provider's current claims submissions. In the event that an overpayment of a claim or claims is offset against the Provider's current claim or claims, pursuant to this section, Anthem Blue Cross will give the Provider a detailed written explanation identifying the specific overpayment or payments that have been offset against the specific current claim or claims. In some cases, the overpayment is referred to a collection service.

General Guidelines

Anthem Blue Cross establishes and, from time to time, revises unit values based on observed charge patterns of physician's Current Procedural Terminology (CPT) and Centers for Medicare & Medicaid Services (CMS) and Healthcare Common Procedure Coding System (HCPCS) Level II codes. The presence of a code in the current CPT, HCPCS or other procedural manuals does not necessarily indicate Anthem Blue Cross allows the services. Anthem Blue Cross retains discretion in the determination of payment structures.

Anthem Blue Cross uses these guidelines for administrative purposes, such as claims processing and developing guidelines for Medical Review and Medical Policy.

The following are general claim submission guidelines:

1. 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 are returned.

   HCPCS and CPT Codes. Current HCPCS and CPT Manuals must be used because many changes are made to these codes every year. Anthem Blue Cross uses only current HCPCS and CPT codes. These manuals may be purchased at any technical bookstore, or by writing to:

Mail Orders
American Medical Association
Attention: Order Processing
P.O. Box 930876
Atlanta, GA 31193-0876

Or, by calling:

a. MedicalCodingBooks.com: 866-900-8300
b. The American Medical Association: 800-621-8335

2. Reimbursement for HCPCS Level II Codes
   a. Pharmacy (including infusion therapy drugs). For Standard Prudent Buyer contracts, the statewide maximum allowable is based on 106 percent of average sale price (ASP) for drugs as published by the CMS, effective the first day of the calendar quarter following the quarterly CMS effective date. In the event that no ASP for drugs has been published by CMS for a specific drug, the statewide maximum allowable will be established by Anthem Blue Cross, considering claims and/or external data, including average wholesale price (AWP). The statewide maximum allowable for immune globulins, vaccines, and toxoids will be established by Anthem Blue Cross and considers claims and/or external data, including AWP, which will be updated quarterly. Self-injected drugs for home use and all oral prescription drugs dispensed in the physician office will be denied, and the Member may not be billed by the physician or other health care clinician. These drugs must be provided by a licensed pharmacy.
   b. Injectable medications. Injectable medications that are administered in the physician's office and/or other medical Facility can be reimbursed when using the appropriate code that best describes the dosage being administered. To ensure appropriate allowances, include the units of occurrence in box "24G" (Units-Days) on the *CMS-1500* form.
   c. Durable Medical Equipment (DME) Supplies including, but not limited to, infusion therapy supplies, Prosthetics and Orthotics. The maximum allowable will be determined by Anthem Blue Cross, based on claims data and/or external data. The maximum allowable will be based on whether the equipment is new, used or rented, as identified by the HCPCS Level II code modifier. Anthem Blue Cross may designate certain items as "rental only," "purchase only" or "rent to purchase." For "rent to purchase" items, the maximum allowable is the Anthem Blue Cross-determined purchase price; the rental price will not exceed the purchase price.
   d. Other HCPCS Codes. For other HCPCS codes, the maximum allowable will be determined by Anthem Blue Cross using claims data and/or external data.
3. Split-Year Claims. For services that begin before December 31, but extend beyond December 31, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and copayment maximums. Therefore, submit claims by single year only.
4. Modifiers. A modifier indicates that the procedure performed by the physician has been altered by some specific circumstance, but has not changed in its definition or code. The presence of a modifier in the current CPT, HCPCS or other procedural manuals does not necessarily indicate Anthem Blue Cross allows the services. Anthem Blue Cross retains discretion in the determination of payment structures. The use of modifiers is critical to the editing and reimbursement of services.

For additional details on pricing/reimbursement and editing rules, coding requirements, and the impact of modifiers, please refer to the Anthem Blue Cross *Global Pricing Policy* and additional documents located in the *Policies and Procedures* of ProviderAccess® at: anthem.com/ca/home-providers.html

5. Cardiac Catheterization. For cardiac catheterization codes, physicians are required to bill with Modifier 26 to reflect the professional service.
6. Anesthesia Codes and Modifiers. To be consistent with industry guidelines, Anthem Blue Cross changed its anesthesia service billing procedures to conform to the practice of using only current CPT codes 00100 through 01999 when billing for anesthesia administration. Anthem Blue Cross does not accept the practice of billing anesthesia services using surgical codes with a modifier (e.g., 23, 30 or P1).

   In addition, when two or more anesthesia procedures are billed during the same operative session, only the anesthesia procedure with the most complex procedure is allowed for reimbursement. This is consistent with ASA guidelines.
7. Anesthesia Time. To more accurately calculate and reimburse health care professionals for anesthesia services, Anthem Blue Cross requires all anesthesia services to be billed using minutes.
8. Unlisted Procedure or Service. There may be services or procedures performed by Providers that are not found in CPT; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, Anthem Blue Cross needs a description of the service to calculate the appropriate reimbursement, and medical records.
9. CPT Code 99070. CPT code 99070 (supplies and materials provided by the Provider over and above those usually included with the office visit or other services) is not accepted by Anthem Blue Cross. Providers are to use HCPCS Level II codes, which give a detailed description of the service provided. Anthem Blue Cross will follow Medicare guidelines where applicable (i.e., surgical trays considered incidental) and will not be payable separately.
10. Multiple Surgeries. Multiple surgery claims are priced based on major and minor procedures. The surgical procedure with the highest Relative Value Unit (RVU) is considered the major procedure and is priced at 100 percent of the unit value. The minor surgeries have a lesser unit value and are reimbursed at a reduced allowable.
11. Laboratory Claims. Physicians must supply laboratories with a diagnosis, correct patient information (including full name and date of birth) and appropriate billing information. This information is important to ensure that laboratories have the appropriate information to bill Anthem Blue Cross.

    For additional details on pricing/reimbursement and editing rules, coding requirements, the impact of modifiers, and Reimbursement Policies affecting the final outcome of editing and pricing please refer to the Anthem Blue Cross *Global Pricing Policy* and additional documents located in the *Policies and Procedures* of ProviderAccess® at: anthem.com/ca/home-providers.html
12. National Drug Code Requirements

    For dates of service on or after January 1, 2015, all professional Providers are required to supply the 11-digit NDC when billing for injections and other drug items on the *CMS-1500 Claim Forms* as well as on the 837 electronic transactions.

Note: These billing requirements will apply to Local Plan and BlueCard Member claims only, and will exclude Coordination of Benefits/Secondary claims.

Line items will deny if Not Otherwise Classified or Miscellaneous Healthcare Common Procedure Coding System (HCPCS) codes are billed for physician administered drugs AND do not include the following:

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

Unit of Measurement Requirements

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

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

Location of the NDC

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

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

Correcting Omission of a Leading Zero

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

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

  See the examples that follow:

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

Process for Multiple NDC numbers for Single HCPCS Codes

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

How/Where to Place the NDC on a Claim Form

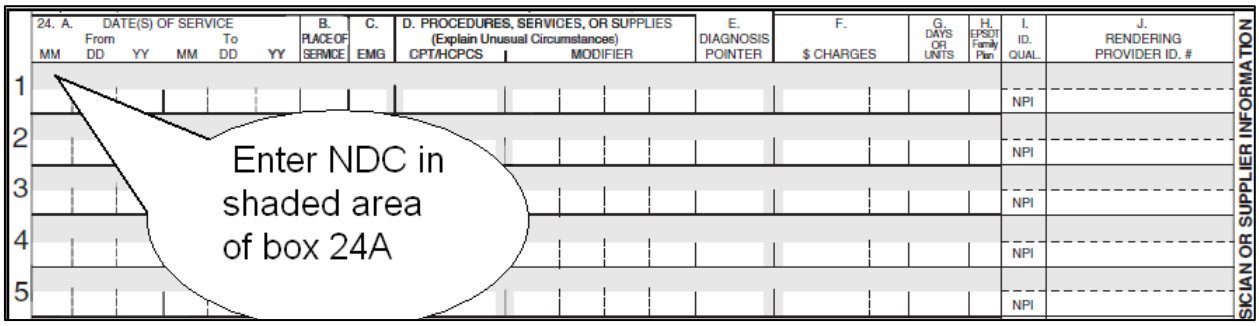
CMS-1500 Claim Form:

- Reporting the NDC requires using the upper **and** lower rows on a claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- DO NOT **bill more than one NDC per claim line.**
- Even though an NDC is entered, it must be a valid NDC, and a valid HCPCS code must also be entered in the claim form.
- If the NDC you bill does not have a specific HCPCS code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- The number of NDC units dispensed is very important as the allowed amount for each NDC reflects one unit of measure.

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

All Elements are REQUIRED:

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



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 common situations:

1. Alpha prefix on Subscriber ID not provided, incomplete, illegible or inaccurate for BlueCard®. The three-digit alpha prefix is critical for properly identifying and routing all paper claims (e.g., Blue Cross and/or Blue Shield plans, such as the BlueCard PPO). The alpha prefix identifies the Member's Blue Cross and/or Blue Shield plan.
2. Authorization Numbers. Include applicable authorization/pre-certification numbers. Servicing Providers should include the "order number" (also known as a "preauthorization number") for imaging services authorized by AIM® (American Imaging Network).
3. *CMS-1500 Claim Form* not used. Participating Providers are required to submit all hard copy claims on the most current *CMS-1500* form.
4. Date of injury not provided. When charges represent an injury diagnosis, provide a date of injury.
5. Other carrier Explanation of Benefits (EOB) not provided. When billing Anthem Blue Cross as a secondary payor, a copy of the primary carrier's EOB must be attached. Be aware if the primary carrier for the patient is unable to process the claim for benefits, due to missing information, Anthem Blue Cross will not be able to apply the secondary benefits until a final determination is made by the primary carrier in regards to benefit application. In events such as this you will need to follow up with the primary carrier to obtain another EOB, which shows the benefits were applied. Anthem Blue Cross will not contact the primary carrier to have their EOB corrected and resubmitted.
6. Duplicate billings. Overlapping dates of service for the same service(s) create a questionable duplicate bill.
7. DSM-IV diagnosis coding denied. ICD-9 OR successor codes should be used when billing diagnosis codes.
8. ICD-9-CM codes denied. Claims that are coded with a preliminary, rather than a definitive diagnosis, are mailed back for the definitive diagnosis.
9. Illegible claim form or data. To ensure readable image quality, do not hand-write claim forms avoid submission of dot-matrix printed documents and lightly printed or carbon forms. If your billing system is not computerized, type the claim form. Stamp or write messages 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 able to be processed. Use the "Remarks" field to stamp or write "Tracer" or "Past Due" on the claim.
10. Member identification number is incomplete. Specifically in the case of Federal Employee Program (FEP) (except for Blue Cross HMO FEP) claims, the alpha prefix is omitted in addition to other numeric digits. The FEP ID number starts with the letter "R" and has eight numeric digits that follow the letter "R." Supply the nine-digit ID number for all FEP submissions.
11. Modifier invalid. Make sure the correct modifier is submitted when required.
12. Request for medical records. When returning records to Anthem Blue Cross, it is imperative that

the records are attached to the original mail-back form. Do not reattach a new copy of the claim. 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.** A full description of unlisted HCPCS codes should be included on claims. When submitting claims electronically, enter the description in the "Remarks" field. If the unlisted service is within the surgery range of coding please also submit a detailed operation report for unlisted service.
14. **Unreasonable numbers submitted.** Do not use unreasonable numbers (e.g., 999) in the "Units" field; units greater than 999 should be indicated on the claim or in the "Remarks" section, if billing electronically.

The following situations may not result in rejected or returned claims, but are very likely to cause payment delays:

1. **Assignment of benefits missing or not clear.** If an assignment of benefits is missing, indicated on a form other than the *CMS-1500 Claim Forms* or otherwise not legible, most often the payment will be remitted to the Member. To avoid delays, obtain the Member's signature on an Assignment of Benefits form and indicate on your claim form that this is on file. Anthem Blue Cross does not provide an assignment of benefits form.
2. **Group practice tax identification numbers.** If the tax identification number is that of a group practice, the rendering Provider's name and state license number must appear on the claim. In addition, the location where services were rendered must be included.
3. **National Provider Identifier (NPI).** Anthem Blue Cross encourages submission of a practitioner's NPI on all claims.

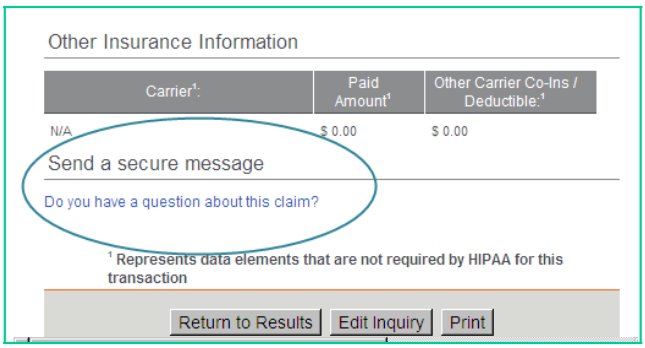
! *Secure Messaging – Availity Web Portal*

- The Availity Web Portal provided the opportunity to "ask a question" about a claim online. You can send a 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, which allows a user to send a question online about a claim. This functionality is only available on the Availity Web Portal. Secure messages can be sent for local Anthem Blue Cross, Anthem Blue Cross Blue Shield (Anthem), BlueCard® out-of-area, and FEP (Federal Employee Program) Member claims. If you received a bar-coded mail-back letter, place the mail-back letter on top of the requested information and following mailing instructions.

How do I send a Secure Message?

To send a secure message:

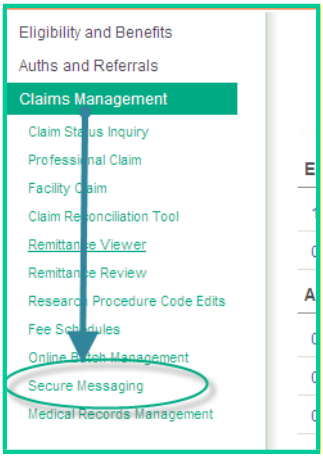
- Click on the link "Do you have a question about this claim?"



- 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 additional information related to your question and click "submit." You will receive an Inquiry Control Number (ICN), which confirms your Secure Message has been sent.

How are Secure Message processed?

- Your secure message is routed to Anthem Blue Cross 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 Management 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.

- Providers often resubmit copies of claims that have been rejected or denied. Secure Messaging will help Providers avoid submitting duplicate claims and lessen your administrative burden by getting the claim reprocessed as expeditiously as possible.

Secure Messaging should be used when you would like 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

Note*:* Billing/claim reimbursement questions can be submitted electronically through Claims Inquiry and Secure messaging accessible on Availity for local Anthem Blue Cross, Anthem Blue Cross Blue Shield (Anthem), BlueCard out-of-area, and FEP (Federal Employee Program) Member claims. See section titled *Dispute Resolution Process for Contracted Providers* for more information.

For FEP, for services rendered in the state of California, Covered Individuals submit the form and documents to the address shown below. Professional Providers use the same address for submitting claims on a *CMS-1500* form:

FEP
Blue Shield of California
P.O. Box 272510
Chico, CA 95927

Electronic Data Interchange (EDI)

EDI allows Providers 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 Blue Cross 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 a.m. – 4:30 p.m. PT
Monday – Friday
Phone: 800-470-9630
Email: e-solutions.support@anthem.com
Website/Live Chat: anthem.com/edi

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; or
- 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

Ensure crossover claims are forwarded appropriately and remember to always include:

- Complete Health Insurance Claim Number (HICN)
- Covered Individual's complete ID number, including the three character alpha prefix
- Covered Individual's name as it appears on the Covered Individual's ID card, for supplemental insurance

Reduce Duplicate Billing:

- Do not file with us and Medicare simultaneously.
- Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare.
- Payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued. CMS requests that you do not bill your patients' supplemental insurers for a minimum of fifteen (15) work days after receiving the Medicare payment.
- After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer. If the claim was crossed over, the payment advice/EOMB should typically have "Remark Code MA 18" or N89 printed on it, which states, "The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them." The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits.

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.

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. Please 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, please 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 payor's 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, please 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.

ERA/EFT	Contact
Enrollment, Banking or Vendor Changes, File Delivery's and Formatting	EDI Vendor EDI Solutions Specialist: Phone: 800-470-9630 Email: e-solutions.support@anthem.com Website: anthem.com/edi
ERA – Claim adjudication, payment and remark codes EFT– Bank Posting, Payment Delivery/Amount Questions	Provider Care: 800-677-6669 EDI Solutions: 800-470-9630
Anthem Delivery Schedule, File and Field Definition	Anthem Blue Cross HIPAA Companion Guide Available online at anthem.com/edi > Select State > documents > HIPAA Companion Guide > 835 Payment Advice

Should Provider or Facility 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 or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

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 Covered Individuals, including BlueCard

Anthem has electronic solutions, giving Provider's access to the Covered Individual'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) 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 Covered Individual liability (deductible, copayment, 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 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 Medical Electronic Attachment, Inc. (MEA) at 888-329-9988.

Hard Copy Billing

Participating health care professionals that are not set up to process claims electronically or are submitting their claims in a bundled packet associated with a global case rate period, are required to submit all hard copy claims on the *CMS-1500* 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 is:

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

For FEP, for services rendered in the state of California, Covered Individuals submit the form and documents to the address shown below. Professional Providers use the same address for submitting claims on a *CMS-1500* form:

FEP
Blue Shield of California
P.O. Box 272510
Chico, CA 95927

Some Anthem Blue Cross Covered Individuals may have their claims administered by a third-party administrator, capitated group or other organization outside of Anthem Blue Cross. These claims must still be routed directly to the address currently printed on the Member's ID card, as previously instructed. If you are unsure about a claims address, contact Customer Service at the phone number on the back of the Member's ID card.

Tips for Clean Paper Claims Submission

1. **Tracer claim (possible duplicate).** 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 the claim using ProviderAccess. For more information on ProviderAccess, refer to the *ProviderAccess® and the Availity Web Portal (Availity)* section of this Manual.
2. **Invalid or missing license number.** A valid license number must be included on the claim.
3. **Tax identification number invalid.** All professional claims must include an accurate tax identification number.
4. **Provider Locator Code missing.** Include your locator code if multiple addresses or offices are on our database, so your payment can be sent to the correct location.
5. **Member not identified.** Verify that membership data, such as certificate number and group numbers, including prefixes, are correct. If the Member is from out-of-state, include a copy of his or her ID card.
6. **Invalid date of birth.** Date of birth must be included and correct. Be careful not to transpose the dates.
7. **Code invalid.** Verify that ICD-9 OR successor codes, CPT/HCPCS and procedure codes are appropriate and valid.

8. **Modifier invalid.** Make sure the correct modifier is submitted when required.
9. **Diagnosis code not referenced.** All diagnosis codes on professional claims must be referenced to a procedure. For example, if you list three diagnosis codes, the second and third diagnosis codes must also be referenced to at least one procedure code.
10. **Possible duplicate line on same claim.** Detail-line items on the same claim should be checked to ensure that they are not duplicated.
11. **Detail line incomplete.** Verify that all fields are completed accurately.
12. **Include all attachments.** This means medical records, surgical reports, prior authorizations, etc., when required. Providers that submit claims electronically can take advantage of secure electronic attachments. To learn more about electronic claims submission, see *Electronic Claims Submission* in this section or go to anthem.com/edi > select California. If you already submit claims electronically, see *Electronic Claims Attachments* in this section or contact Medical Electronic Attachment, Inc. (MEA) at 888-329-9988, ext. 2 to find out how to save time and money sending electronic attachments securely.
13. **Illegible claim form or data.** To ensure readable image quality, avoid submission of dot-matrix printed documents and lightly printed or carbon forms. Stamp or write messages 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 easily processed. Use the "Remarks" field to stamp or write "Tracer" or "Past Due" on the claim.

Erroneous or duplicate Claim payments under the Federal Employee Health Benefit Program (FEHBP)

For erroneous or duplicate claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous claim payments regardless of the cause. Such refund or adjustment may be made 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.

Where and How to Submit BlueCard® Program Claims

You should always submit Anthem BlueCard claims to:

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

Include the Member's complete ID number when submitting the claim. The complete ID number includes the three-character alpha prefix. Incorrect or missing alpha prefixes and Member ID numbers delay claims processing.

Once Anthem Blue Cross receives the claim, it will electronically route the claim to the Member's Anthem Blue Cross and Blue Shield Plan. We will work with the Member's Plan to process the claim and the Member's Plan will send an explanation of benefit or EOB to the Member. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the Members benefits and coverage.

If you are a non-PPO (traditional) Provider and are presented with an ID card with the "PPO in a suitcase" logo on it, you should accept the card and file with Anthem Blue Cross. We will send you an explanation of payment or the remittance advice and issue the payment to you under the terms of our contract with you and based on the Members benefits and coverage.

International Claims

The claim submission process for international Blue Cross and/or Blue Shield Plan Covered Individuals is the same as for domestic Blue Cross and/or Blue Shield Plan Covered Individuals. You should submit the claim directly to Anthem Blue Cross.

Indirect, Support or Remote Providers

If you are a health care Provider that offers products, materials, informational reports and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support or remote Provider. Examples include, but are not limited to: prosthesis manufacturers, DME suppliers, independent or chain laboratories, and telemedicine Providers. If you are an indirect Provider for Covered Individuals from multiple Blue Plans, follow these claim-filing rules:

- If you normally send claims to the direct Provider of care, follow normal procedures.
- If you do not normally send claims to the direct Provider of care, file the claim with Anthem Blue Cross.

Exceptions to BlueCard® Claims Submissions

Occasionally, exceptions may arise in which Anthem Blue Cross will require you to file the claim directly with the Member's Blue Plan. Here are some of those exceptions:

- You contract with the Member's Blue Plan (for example, in contiguous county or overlapping service area situations).
- The ID card does not include an alpha prefix.

In some cases, Anthem Blue Cross will request that you file the claim directly with the Member's Blue Plan. For instance, there may be a temporary processing issue at Anthem Blue Cross, the Member's Blue Plan, or both that prevents completion of the claim through the BlueCard Program.

When in doubt, send the claim to Anthem Blue Cross at:

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

We will handle the claim for you.

FEP Claims address, for services provided by professional Providers in CA:

Blue Shield of California
P.O. Box 272510
Chico, CA 95927

Claims for Accounts Exempt From the BlueCard Program

When a Member belongs to an account that is exempt from the BlueCard Program, Anthem Blue Cross will electronically forward your claims to the Member's Blue Plan. That means you will no longer need to send paper claims directly to the Member's Blue Plan. Instead, you will submit these claims to Anthem Blue Cross. Medicare Supplemental and Medicare Risk are required to put alpha prefixes on their Covered Individuals' ID cards. However, you will continue to submit Medicare Supplemental (Medigap) and other Coordination of Benefits (COB) claims under your current process.

How the Electronic Process Works

- You will submit claims with alpha prefixes directly to Anthem Blue Cross, which will forward the claims to the Member's plan for you.
    - It is important for you to correctly capture the Member's complete ID number on the claim, including the three-character alpha prefix at the beginning. If you don't include this information, Anthem Blue Cross may return the claim to you, and this will delay claims resolution and your payment.
    - It is also important for you to call BlueCard Eligibility at 800-676-BLUE, or 800-676-2583, to verify the Member's eligibility and coverage.
- If the Member's claim is exempt from the BlueCard Program, Anthem Blue Cross will inform you that the claim is being forwarded to the Member's plan. In some cases, the Member's Blue Plan may contact you for additional information. For example, if the Member's plan cannot identify the Member, the Member's Blue Plan may return the claim to you just as it would currently with a paper claim. If this happens, verify the billing information and resubmit the claim with the additional or corrected information to Anthem Blue Cross.
- The Member's Blue Plan will send you a detailed EOB/Payment Advice with your payment or a notice of denial. If you have already been paid or you do not contract with Anthem Blue Cross, the Member's Blue Plan may pay the Member.

Coordination of Benefits (COB) Claims

COB refers to how we make sure people receive full benefits, and how we prevent double payment for services when a Member has coverage from two or more sources. The Covered Individual's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If after calling 800-676-BLUE, or 800-676-2583, or through other means you discover the Member has a COB provision in his or her benefit plan and another insurance carrier is the primary payor, submit the claim, along with information regarding COB, to Anthem Blue Cross. If you do not include the COB information with the claim, the Member's Blue Plan or the other insurance carrier will investigate the claim. This investigation could delay your payment or result in a post-payment adjustment.

Coordination of Benefits for FEP

In certain circumstances when FEP is the secondary payor and there is no adverse effect on the Covered Individual, we may take advantage of any Provider discount arrangements the primary payor may have and only make up the difference between the primary plan's payment and the amount the Provider has agreed to accept as payment in full from the primary plan.

FEP Program Requirements

Network/Participating Provider acknowledges and understands that Anthem participates in the Federal Employee Health Benefit 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. Network/Participating Provider further understands and acknowledges 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. Network/Participating Provider agrees 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. Network/Participating Provider further agrees that in the event of a conflict between this Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulation, 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 and local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Payment for BlueCard® Claims

If you haven't received payment, do not resubmit the claim. If you do, it will be denied as a duplicate. This will also confuse the Member because he or she will receive another EOB and will need to call Customer Service. Timing for claims processing varies at each Anthem Blue Cross and Blue Shield Plan. You can check the claim payment in ProviderAccess®, at https://provider2.anthem.com/wps/portal/ebpmybcc

For more information about this service, refer to the *ProviderAccess® and the Availity Web Portal (Availity)* section of this Manual.

In some cases, a Member's Blue Cross and/or Blue Shield Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, Anthem Blue Cross may either ask you for the information or give the Member's plan permission to contact you directly.

How to Handle Calls From Covered Individuals and Others With Claims Questions

If a Member contacts you, tell them to contact their Blue Cross and/or Blue Shield Plan. Refer them to the front or back of their ID card for a Customer Service number. The Member's plan should not be contacting you directly, unless you filed a paper claim directly with that plan. If the Member's plan contacts you to send another copy of the Member's claim, refer the plan to Anthem Blue Cross.

Where to Find More Information About the BlueCard® Program

For more information about the BlueCard Program, call Anthem Blue Cross at 800-444-2726, or visit the Blue Cross and Blue Shield Association's website at www.bcbs.com/

Health Care Professional License

Anthem Blue Cross requires health care professionals to include their state license number and the ZIP code for their practice (the location where services are rendered) when submitting claims. All professional claims submitted to Anthem Blue Cross must include this information, consistent with the Agreement. If the tax identification number is that of a group, the rendering Provider's name and license number must also appear on the claim. All license numbers are validated against the license number file from the California Board of Consumer Affairs.

On the *CMS-1500* form, the rendering National Provider Identifier (NPI) is entered in box number "24J" and the ZIP code in box number "32" or corresponding fields for an 837 transaction (electronic). The rendering NPI and practice ZIP code requirements apply to optical character recognition (OCR) scannable paper claims, non-scannable *CMS-1500* paper claims and electronically submitted claims.

Claims submitted without a state license number may be returned and have processing delays.

The following areas or health care professionals are not required to provide Anthem Blue Cross with a state license number (exempt health care professionals must still include practicing ZIP code):

- Air ambulance
- Blood bank
- Christian Science nurse
- Christian Science practitioner
- Donor bank
- Group ambulance
- Independent laboratory
- Medical vendor (DME)
- Magnetic resonance imaging (MRI)
- Optician
- Orthotics/prosthetics
- Pharmacy
- Portable X-ray
- Blue Cross PPO clinical laboratory
- Blue Cross PPO diagnostic imaging/MRI

Claim Submission Filing Limits

Physicians and Behavioral Health Providers must submit a claim to Anthem Blue Cross on forms and in a manner acceptable to Anthem Blue Cross within 12 months of rendering services described in the claim. **Note: Ancillary Providers (Ambulance, Audiologists, DME, Hearing Aid Dispensers, Home Infusion, Physical, Occupational and Speech Therapists) should refer to their Agreement to verify the time limit for filing claims.** Anthem Blue Cross may contractually deny a claim submitted beyond that 12-month claim-filing limit. The Providers shall furnish, on request, all information reasonably required to verify and substantiate the provision of services, their Medical Necessity and the charges of such services. The patient/Member to whom the services were rendered is not liable for the amount of the claim. If the Provider believes that the claim was, in fact, submitted timely despite Anthem Blue Cross' denial, the Provider may submit evidence of such timely filing. Such evidence must be attached to the back of the Anthem Blue Cross mail-back or denial EOB, and submitted in a timely manner for reconsideration of the initial denial. **Do not resubmit the original claim.**

! When behavioral health benefits are carved-out to a non-Anthem Blue Cross insurance carrier, timely filing limits may be different than the timely filing limits in the Agreement.

Submission of Claims Under the Federal Employee Health Benefit Program

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 carrier's explanation of benefits. Network/Participating Provider agree to provide to Plan, at no cost to Anthem or Covered Individual, 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 Covered Individual did not provide Plan identification, Network/Participating Provider shall not bill, collect, or attempt to collect from Covered Individual for claims Plan receives after the applicable period regardless of whether Plan pays such claims.

FEHBP Waiver Requirements

Waiver Requirements for FEHBP:

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

Note: The 12-month claim-filing limit also applies to adjustments when Anthem Blue Cross is the primary carrier. For claims involving COB with another carrier or Medicare, the date of the other carrier's EOB or Medicare's EOB is used for determining the eligible submission period.

In many cases, Anthem Blue Cross will accept such resubmitted claims. Anthem Blue Cross may, for example, accept the following as evidence of timely electronic submission:

- Computer-generated billing ledgers with the Anthem Blue Cross name from a billing system.
  - If a locator code is used instead of the billing address, a list of locator codes/corresponding addresses must be provided.
  - A ledger must have several claims listed.
- Clearinghouse report (e.g. EMDEON) of acceptance by Anthem Blue Cross.
- *Dated request for Additional Information* form (from Anthem Blue Cross).
- Anthem Blue Cross-generated *Positive Acknowledgement Report.*
- Claim denial letter or EOB from Anthem Blue Cross.
- For EDI claims that could not be processed by Anthem Blue Cross:
  - Copy of Anthem Blue Cross' dated letter to Provider requesting a resubmission; or
  - Anthem Blue Cross Batch Number for claims (or other identifying information) or error listing.

Anthem Blue Cross may, for example, accept the following as evidence of timely hard copy submission:

- Computer-generated claim transaction history with the Anthem Blue Cross name from a billing system.
  - If a locator code is used instead of the billing address, a list of locator codes/corresponding addresses must be provided.
  - You must include billing history and history of timely follow-up attempts made within contracted timely filing guidelines.
  - A ledger must have several claims listed.
- Dated *Request for Additional Information* form (from Anthem Blue Cross).
- Claim denial letter or EOB from Anthem Blue Cross.

Anthem Blue Cross accepts the following as proof of submission when initially sent to another carrier:

- Denial letter, dated and printed on letterhead, from other insurance carrier; or
- Dated EOB from other insurance carrier

HIPAA regulations do not allow us to request documents that contain more than just the claim in question and, in addition, if the Provider sends us a ledger with multiple claims listed, then the Provider would be in violation of HIPAA.

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

Anthem Blue Cross may, for example, not accept the following as evidence of timely submission:

- Reports from the Provider system indicating that the claim was submitted to the clearinghouse. (In some cases, claims error out and do not enter the Anthem Blue Cross claims system; the originator receives notice of these in the form of an error report.)
- Patient transaction history without consistent and timely follow-up attempts made within contracted timely filing guidelines.

Billing References

This Manual, when used with the following references, provides detailed instructions on billing:

1. *CPT-4* (current year). American Medical Association. To order, call 800-621-8335.
2. *CMS Healthcare Common Procedure Coding System* (HCPCS), National Level II (current year). Practice Management Information Corporation (PMIC). To order, call 800-633-7467 (MED-SHOP).
3. *ICD-9-CM,* Fifth Edition, Ninth Revision, Volumes 1, 2, 3 (2000). Practice Management Information Corporation (PMIC). To order, call 800-633-7467 (MED-SHOP).
4. National Uniform Claim Committee for *CMS-1500 Claim Form* instructions. Visit nucc.org.

Ambulance

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Introduction

This section outlines billing guidelines and identifies useful coding for use in conjunction with the *Claims Submission* section of this Manual to help the Ambulance Network Provider reduce the number of returned claims.

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 network.

Ambulance

The following information outlines specific billing requirements for ambulance services. It is highly recommended that health care professionals bill according to these requirements to avoid having their claims returned to them.

1. If you are not billing electronically using *Electronic Data Interchange* (EDI), use a *CMS-1500 Claim Form* (formerly the *HCFA-1500 Claim Form)*. If you are billing Anthem Blue Cross secondary to Medicare, you must bill Anthem Blue Cross using the *CMS-1500 Claim Form*, not the *CMS-1491*. You can get this form from any publisher of medical forms/publications.
2. Provide the appropriate Healthcare Common Procedure Coding System (HCPCS) Level II code(s) in field 24D of the *CMS-1500 Claim Form*. Use the codes found in Exhibit A of the *Anthem Blue Cross Comprehensive Participating Provider Agreement* (Agreement).
   - Advanced Life Support (ALS) emergency service base rate
   - ALS non-emergency service base rate
   - ALS mileage
   - Basic Life Support (BLS) emergency service base rate
   - BLS non-emergency service base rate
   - BLS mileage
   - Conventional air service base rate
   - Fixed wing mileage
   - Helicopter service base rate
   - Rotary wing mileage
   - Specialized equipment and personnel not usually carried/staffed on an ambulance
3. Bill your retail (list) rates, not the contracted amount, unless otherwise stated in your contract.
4. Use the appropriate HCPCS National Level II modifiers on the base rate codes to indicate the origin and destination of the ambulance transportation provided. These modifiers are listed in the *HCPCS Level II* book.
5. Billing for a “dry run.” A “dry run” is the emergency response and care by paramedics when no transportation is provided and the service is requested through the 911 Emergency Response System (ERS). The correct way to bill for a “dry run” is to use HCPCS Level II code “A0999,” with modifier UC. One of the following must have occurred for the claim to be reimbursed:

- The Covered Individual reasonably believes that the medical condition was an emergency medical condition requiring an emergency response; or
- The ambulance team believes there is an emergency, but, based on advice from a medical doctor, they treat the patient on the scene and do not provide transportation.

  Note: Attach documentation to the claim that includes the circumstance(s) that caused the 911 response and the reason(s) for non-transport.

6. Bill all loaded (Covered Individual-on-board) miles with the appropriate mileage code and with the number of loaded miles traveled listed in box 24G of the *CMS-1500 Claim Form*.
7. The originating transport address, including the ZIP code, must be listed in box 32 of the *CMS-1500 Claim Form*. Use the ZIP code where the Covered Individual was picked up.
8. Complete all information on the *CMS-1500 Claim Form*:
   - Subscriber/Covered Individual information – fields 1 to 16
   - Referring physician information – field 17
   - Provider services information – fields 18 to 22, 24 and 28 to 30
   - Authorization code, if applicable (e.g., for HMO Covered Individuals) – field 23
   - Provider information – fields 25 to 27 and 31 to 33

For some Anthem Blue Cross Covered Individuals, claims are administered by a third-party administrator, a capitated group or other organizations outside of Anthem Blue Cross. These claims must be routed directly, as instructed, to the address currently printed on the Anthem Blue Cross Covered Individual's ID card.

When you receive the payment and Explanation of Benefits (EOB), it will show the contract discount and the amount (if applicable) of the deductible and/or copayment that the Subscriber/Covered Individual is responsible and may be billed for. Covered Individuals may not be billed for services that have been denied by Anthem Blue Cross as not medically necessary, unless the Covered Individual agrees to it in advance, in writing, on a form approved by Anthem Blue Cross.

If you have issues about a claim payment, call the Customer Service numbers on the Covered Individual's ID card, or submit a written request to the Post Office box on the Covered Individual's ID card.

The Covered Individual's contract will allow for either ground transport or for both ground and air ambulances. When the contract language is not specific but states that ambulance services are covered, Anthem Blue Cross will consider both ground and air ambulance services for payment.

Pricing for all ambulance services is based either on the negotiated rates found in *Exhibit A* of the Agreement or the health care professional's covered billed charges, whichever is less.

For those agreements that specify a percentage discount off the covered billed charges, payment for all Covered Services will be allowed at the negotiated percentage, discounted from established rates. For more information, see the *Reimbursement* section.

Eligible Services

The following are considered eligible Covered Individual services. Inclusion in this list does not mean the service will be separately and/or distinctly reimbursed:

- Ambulance transportation to a hospital or Skilled Nursing Facility (SNF)
- Ambulance transportation from a hospital or SNF
- Ambulance transfer to a different Facility during an eligible continuous hospital or SNF stay, including transportation from nonparticipating to participating Facilities; a transfer for convenience is not covered, unless approved by Case Management
- Ambulance transportation from a hospital or SNF to another Facility for diagnostic or therapeutic services that are not available in the admitting hospital
- Continuous trips when both ground and air ambulances are needed to transport a Covered Individual to a hospital or SNF
- Ambulance charges when the Covered Individual is declared dead on arrival
- The base charge that includes the service of ambulance attendants and the use of reusable equipment and devices
- Mileage from the point of pick up to the destination
- Advanced life support services including, but not limited to:
  a) IV administration
  b) Application of anti-shock trousers
  c) Application of electrical countershock to the heart
  d) Establishing and maintaining a Covered Individual's airway
- Non-reusable supplies, such as gauze and dressing, injectable medications, intravenous solutions, oxygen, and tubing

Non-eligible Services

The following are considered non-eligible Covered Individual services:

- Transportation in a vehicle that is not a licensed ambulance (e.g., taxi, wheelchair van, bus, etc.)
- Paramedic or emergency medical technician services, except for 911 calls
- Search and rescue services
- Transportation that is not either to or from a legally operated hospital or SNF
- Reusable devices, such as backboards, and leg and arm splints
- Ancillary charges for parking fees, tolls, meals and lodging
- Infectious control or ambulance cleaning; ambulances are cleaned after each transport and the cost is included in the base charge

The following unusual conditions and services are considered non-eligible Covered Individual services:

- Climbing or descending stairs
- Handling an overweight patient

- Bad road or weather conditions
- Services on a weekend
- Risk factors, such as communicable diseases
- Telecommunication services

Reimbursement Overview

The Agreement establishes a network to service all Anthem Blue Cross Covered Individuals. This Agreement consolidates Anthem Blue Cross PPO (Prudent Buyer), Anthem Blue Cross HMO, Anthem Blue Cross Senior Secure and Fee-for-Service plans to allow pricing and reimbursement under a single contract. The Anthem Blue Cross pricing system is programmed to electronically adjudicate the appropriate fee based on the type of bill, the health care professional's tax identification number and any special Anthem Blue Cross billing requirements.

Payment for all ambulance services is based either on the negotiated rates found in Exhibit A of the Agreement, the health care professional's covered billed charges, or amounts specified in any other applicable agreement between the health care professional and Anthem Blue Cross, whichever is less. Payment for Covered Services is based on the rate in effect at the time the service is rendered. Anthem Blue Cross deducts any copayment, coinsurance or deductible amounts from the health care professional's payment.

For those agreements that specify fixed base rates, those rates include all services, supplies, medications, equipment and personnel, except for the following:

1. Air ambulance approved or arranged by Anthem Blue Cross' Managed Care Services may be allowed at the lesser of the rate in Exhibit A of the Agreement, or a rate negotiated by Anthem Blue Cross' Case Management on a case-by-case basis. Some plans have a specific benefit for air ambulance. Call the Customer Service number on the back of the Covered Individual's ID card to verify.
2. Specialized equipment (not usually carried or used for ALS services) approved or arranged by Anthem Blue Cross' Managed Care Services may be allowed at the lesser of the rate in Exhibit A of the Agreement, or a rate negotiated by Anthem Blue Cross' Case Management on a case-by-case basis.
3. Specialized personnel (other than paramedics, EMTs or drivers) approved or arranged by Anthem Blue Cross' Managed Care Services may be allowed at the lesser of the rate in Exhibit A of the Agreement, or a rate negotiated by Anthem Blue Cross' Case Management on a case-by-case basis.

For those agreements that specify a percentage discount off the covered billed charges, Anthem Blue Cross will apply the discount. Unless otherwise specified, health care professionals should bill their regular rates, which in most cases are the maximum rates allowed by the applicable government regulations.

Anthem Blue Cross reimburses the health care professional within 30 working days for indemnity or PPO plans (Prudent Buyer) and within 45 working days for Direct Service plans (Anthem Blue Cross HMO) of receipt of claims that are accurate, complete and in accordance with the Agreement.

If Anthem Blue Cross rejects a claim, the health care professional is notified in writing within 30 working days for indemnity or PPO plans and within 45 working days for Direct Service plans. If a claim is submitted electronically, Anthem Blue Cross reimburses the health care professional within an average of 15 working days of receipt of the claim. If the claim is rejected, the health care professional is notified in writing within an average of 15 working days.

Audiology/Hearing Aid Dispensers

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Audiology/Hearing Aid Dispensers 3

Introduction

This section outlines general billing guidelines for all Anthem Blue Cross commercial plans and senior plans including, but not limited to, Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross Health Maintenance Organization (HMO), Medicare Advantage and Exchanges or Covered California, and identifies useful coding in conjunction with the *Claims Submission* section in this Manual to help audiologists and hearing aid dispensers submit claims to Anthem Blue Cross. Please refer to the *Claims Submission* and *Reimbursement* sections of this Manual for more information about Electronic Data Interchange (EDI), Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Billing Requirements

Anthem Blue Cross billing requirements include the use of current *Centers for Medicare & Medicaid Services* (CMS)*, Healthcare Common Procedure Coding System* (HCPCS), Current Procedural Terminology (CPT) or other assigned codes.

Audiology

The following information outlines billing requirements for audiology services.

Be sure to complete all of the necessary information on the *CMS-1500 Claim Form*:

a) Check the Anthem Blue Cross Member's ID card for the appropriate mailing address.
b) When submitting a claim for an Anthem Blue Cross Member whose policy requires preauthorization, attach the authorization form, or include the authorization number in locator 23 (loop 2300).
c) Provide the appropriate HCPCS or CPT code in locator 24D for each procedure billed. Refer to the current HCPCS or CPT book for appropriate coding.
d) Provide the referring physician's name and Type 1 National Provider Identifier (NPI) number in locator 17 (loop 2310A).
e) Provide the name and address of the Facility where services are rendered in locator 32 (loop 2310AA). Do not use a P.O. Box number.
f) Provide the name, remit address and Type 2 NPI of the billing group/organization in locator 33 (loop 2310AB).
g) For electronic billing provide the rendering practitioner's name, taxonomy code and Type 1 NPI in loop 2310B. Please do not provide this information in loop 2420A.

Hearing Aid Dispensers

The following information outlines billing requirements for hearing aid services.

Be sure to complete all of the necessary information on the *CMS-1500 Claim Form*:

a) Referring Physician Information: Field 17
b) Authorization Code, if applicable: Field 23

c) Claims submitted for binaural hearing aids should be submitted with one unit of occurrence. Binaural amplification means hearing aids in both sides.

Reimbursement

Audiology/Hearing Aid Dispensers

Please refer to Exhibit A of the Agreement for reimbursement. To determine if specific codes are covered and the reimbursement for a code go to ProviderAccess® at anthem.com/ca

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 Provider Care at the number on the Member's health ID card to confirm benefits and eligibility.

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

Diagnostic Imaging

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Introduction

This section outlines general and specific billing guidelines and identifies the coding to be used in conjunction with other information in this Manual to help the Diagnostic Imaging 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). A brief overview of electronic billing and contact information for *Electronic Data Interchange* (EDI) products and services is also included.

Diagnostic Imaging Guidelines

1. Billing requirements per contract. Anthem Blue Cross' billing requirements apply to all Anthem Blue Cross Covered Individual claims except some services administered through Medicaid and other state-sponsored programs.
2. Valid coding. For claims submitted to Anthem Blue Cross, valid *Healthcare Common Procedure Coding System* (HCPCS), or *Current Procedural Terminology* (CPT) codes are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
3. Multiple Procedure Payment Reduction. Anthem Blue Cross follows Medicare's Multiple Procedure Payment Reduction policy for multiple images.

   When two or more diagnostic imaging services are furnished to the same patient on a single date of service, a Multiple Procedures Reduction (MPR) of 50 percent will apply to the technical component (TC) for the diagnostic imaging services that are listed in the "Multiple Procedure Payment Reduction Code List On Diagnostic Imaging" defined by the *Centers for Medicare & Medicaid Services* (CMS) as effective January 1, 2011, (except for code changes/updates necessary in accordance with Section #1 above). This MPR applies only to TC services, and the TC portion of global services. The Multiple Procedure Reduction shall apply to the TC wherein the Anthem Blue Cross allowed amount will be at 100 percent of the technical rate specified by this Agreement for the primary procedure and 50 percent reduction for subsequent procedures performed during a single date of service. The primary procedure is defined as the procedure with the highest priced technical component.
4. Split-year claims. For services that begin before December 31 but extend beyond January 1 of the following year, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and copayment maximums.
5. Contract change during course of treatment. When the Provider's reimbursement is affected by a contract change during a course of treatment, the Provider must split the dates of service to be reimbursed at the new rate.
6. Medical records. Medical records for certain procedures may be requested to determine Medical Necessity.
7. Modifiers. Use the TC modifier when only doing the technical portion of a service.

8. **Unlisted procedures.** There may be services or procedures performed by imaging centers that are not found in the CPT coding book; therefore, specific code numbers for reporting unlisted procedures have been designated. When an unlisted procedure code is used, Anthem Blue Cross needs a description of the service to calculate the appropriate reimbursement, and medical records may be requested.
9. **CPT code 99070.** Anthem Blue Cross does not accept CPT code 99070 (supplies and materials provided by the physician over and above those usually included with the visit or other services).
    a. **Preauthorization review.** The ordering physician must obtain a preauthorization and corresponding order number prior to rendering imaging services.

! Each procedure will require a separate authorization number. Refer to the *Medical Management Programs* section of this Manual for information on AIM Specialty Health (AIM→).

Rendering Providers can obtain information on preauthorizations obtained for their imaging site via AIM's ProviderPortal℠. ProviderPortal is available 24 hours a day, seven days a week and can be accessed online through AIM's secure portal through Anthem Blue Cross' ProviderPortal, ProviderAccess®, at anthem.com/ca. Once in ProviderAccess, select "Referrals & Pre-auths," then "Imaging and Specialty Drug Requests." Additionally, requests may be submitted via telephone by contacting the Call Center toll-free at 877-291-0366.

! A full list of the CPT codes included under AIM can be found on Anthem Blue Cross' ProviderPortal, ProviderAccess at anthem.com/ca. Once you have logged in to ProviderAccess, look for the AIM quick link section on the overview page, and select the AIM Radiology Management Program – Covered Current Procedural Terminology (CPT) Code List. The list may be updated from time to time to reflect changes published by the American Medical Association in the CPT Manual.

Durable Medical Equipment

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Introduction

This section outlines billing guidelines for use in conjunction with the *Claims Submission* section in this Manual to help durable medical equipment (DME) Providers submit claims to Anthem Blue Cross (Anthem).

Please refer to the *Claims Submission* and *Reimbursement* sections of this Manual for more information about Electronic Data Interchange (EDI), Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

DME Billing Requirements

Anthem Blue Cross billing requirements include the use of current *Centers for Medicare & Medicaid Services* (CMS), *Healthcare Common Procedure Coding System* (HCPCS) or other assigned codes.

Bill on a *CMS-1500 Claim Form*. These forms can be obtained from any publisher of medical forms and publications.

Bill following the delivery of products and services. Payment will be denied if a claim is received or dated prior to delivery of products, or prior to completion of service dates.

When you receive the payment and *Explanation of Benefits (EOB),* it will show the contract discount and the amount, if applicable, of the Covered Individual deductible and/or copayment for which the Covered Individual is responsible and may be billed.

If you have issues regarding claims payment, call the Customer Service number on the Covered Individual's ID card.

For further information, see the Plan Compensation Schedule section of your *Comprehensive Participating Provider Agreement.*

Modifiers

For DME, except disposable supplies, inclusion of appropriate modifiers to indicate rental (RR), purchase new (NU) or purchase used (UE) is required:

- If no modifier is used to identify rental, purchase new or purchase used, payment will default to the rental rate on DME.

When Anthem designates items as purchase only, payment will default to the purchase rate.

Use of Miscellaneous Codes

Billing of miscellaneous codes, also known as "unlisted," "not otherwise classified/specified," "unspecified" and "unclassified" should be reserved only when there is no other appropriate HCPCS code to appropriately describe the service rendered. Supporting documentation may be required.

Documentation

Anthem Blue Cross may request documentation to aid in claims processing. This may include, but is not limited to:

- Physician prescription, including diagnosis
- Length of time usage is required, including start and stop timeframes
- Compliance with usage, including reading machine operation time
- Fill requirements for liquid or gaseous oxygen
- Manufacturer's invoice or price/sales quotes, purchase orders or other documentation, which may include a full description and/or pricing information related to equipment
- Physical and clinical findings, including laboratory test results

Units

To aid in accurate and efficient claims processing, Providers should bill supplies and equipment with the appropriate number of units. Examples:

- If a code includes a description of "per 50 strips" and 100 strips were provided, 2 units should be billed.
- If a code includes "per pair" in the description and 1 pair of an item was delivered, 1 unit should be billed, not 2.
- Enteral nutrition codes are billed using 100 calories per unit. If 300 calories are provided, 3 units should be billed.
- For monthly rentals, bill 1 unit per month (not 30 or 31).
- For daily rentals, 1 unit is billed for each day of rental.

Equipment Rentals and Rent to Purchase

Generally speaking, most items that are rented can be converted to a purchase with prior rentals applying to the purchase price of the equipment. Some items are never purchased and the rental reimbursement is not capped at the purchase price. These items are service intensive and monthly rentals will be reimbursed as long as is medically necessary. Examples of continuous rental items may include oxygen-related equipment, ventilators, aspirators and IPPB machines.

Waivers

Covered Individuals may not be billed for non-Covered Services, unless it is agreed to in advance, in writing, by the Covered Individual on either the *Covered Individual (Patient) Responsibility Agreement-Waiver Form*, or a waiver form approved by Anthem Blue Cross. This waiver process must be followed even when the Covered Individual requests upgrades or modifications to equipment that may otherwise be for their convenience or personal enjoyment (for example, the paint color for a wheelchair).

General waivers such as "Covered Individual shall be responsible for all charges not covered by the Covered Individual's insurance carrier" are not sufficient.

Reimbursement

Please refer to Exhibit A of the Agreement for reimbursement. To determine if specific codes are covered and the reimbursement for a code, go to ProviderAccess® at anthem.com/ca.

Home Infusion Therapy

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Introduction

This section outlines general and specific billing guidelines for all Anthem Blue Cross commercial plans and senior plans including, but not limited to, Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross Health Maintenance Organization (HMO), Medicare Advantage and California Exchange products, and identifies useful coding in conjunction with the Anthem Blue Cross Professional Provider Manual and to assist Home Infusion Therapy (HIT) Providers in reducing returned claims.

HIT Providers and Infusion Pharmacies

Billing Requirements

1. Home infusion Providers should always provide their Tax ID number in the appropriate field.
2. 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.
3. 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.
4. Bill with the codes provided at the time your Agreement was implemented as updated periodically. These are the only codes payable under the Agreement.
5. For drugs, bill units in NDC (National Drug Code) codes.
6. For all services, the units of occurrence are a required field. Units of occurrence must be based on the Healthcare Common Procedure Coding System (HCPCS) or Current Procedural Terminology (CPT) description.
7. Bill for no more than 31 days on a claim form.
8. Services allowed under the Agreement include those that are provided in the Member's home.
9. To identify pharmaceuticals *delivered to the patient's home, but not used*, employ modifier SV.

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.

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 Fee Schedule. Certain restrictions will apply to the codes and items that are payable under the Agreement. The fee schedule is updated quarterly by Anthem Blue Cross.

The following are prescription drug benefits and are specifically *excluded* from the Agreement:

- Oral drugs, inhaled and topical medications
- 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.

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
- 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, as well as the information provided in the *Claims Submission* section.

Laboratory

Introduction 2
General Billing Guidelines 2

Introduction

This section outlines general billing guidelines for all Anthem Blue Cross commercial plans and senior plans including, but not limited to, Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross Health Maintenance Organization (HMO), Medicare Advantage and Exchanges or Covered California, and identifies useful coding in conjunction with the *Claims Submission* section in this Manual to help **laboratory** submit claims to Anthem Blue Cross. Please refer to the *Claims Submission* and *Reimbursement* sections of this Manual for more information about Electronic Data Interchange (EDI), Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

General Billing Guidelines

The following are guidelines for submitting laboratory claims to Anthem Blue Cross.

1. **Billing requirements per contract.** Anthem Blue Cross' billing requirements apply to all Anthem Blue Cross Covered Individual claims **except** some services administered through Medicaid programs.
2. **Bill on the new *CMS-1500 Claim Form*.** You can get these forms from any medical forms/publications publisher.
3. **Indicate the referring physician's name and license and NPI numbers** (refer to the *Claims Submission* section for more information on NPI in this Manual) in locator 17, 17a and 17b.
4. **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.
5. **Valid coding.** For claims submitted to Anthem Blue Cross, valid *Current Procedural Terminology* (CPT) codes *or Healthcare Common Procedure Coding System* (HCPCS) are required for all line items billed, whether sent on paper or electronically. Refer to the specific service category for special coding requirements.
6. **Split-year claims.** For services that begin before December but extend beyond December, split claims at calendar-year end. This is necessary to accurately track calendar-year deductibles and copayment maximums.
7. **Contract change during course of treatment.** When the Provider's reimbursement is affected by a contract change during a course of treatment, the Provider must split the dates of service to be reimbursed at the new rate.
8. **Medical records.** Medical records for certain procedures may be requested to determine Medical Necessity.
9. **Modifiers.** Use the technical component (TC) modifier only when doing the technical portion of a service.

Medical Specialty Pharmacy

Introduction 2
Anthem Blue Cross Medical Specialty Pharmacy Drug Pre-Service Medical Review Program 2

Introduction

This section provides information about medical specialty pharmacy.

New developments in medication therapy have resulted in breakthrough treatments for complex diseases. These advances have created a relatively new class of prescription medications that may be referred to as biopharmaceuticals – also known as medical specialty medications or specialty drugs. Medical specialty pharmacy medications may share certain common characteristics, such as being produced by DNA recombinant technology or other biological processes, are high cost and can be injected, infused or inhaled. They generally require close supervision and monitoring of the patient's drug therapy and outcomes. These drugs often require special handling such as temperature-controlled packaging and overnight delivery and are often unavailable at retail pharmacies.

Anthem Blue Cross may designate or classify certain drugs to be medical specialty pharmaceuticals. Certain medical specialty pharmacy medications must be obtained through a participating home infusion or medical specialty pharmacy. Whether or not these specialty medications are to be administered in the Covered Individual's home, freestanding ambulatory infusion suite or other alternate site of care, they must be obtained through a participating home infusion or medical specialty pharmacy. Refer to your Agreement for specific exclusions.

Anthem Blue Cross Medical Specialty Pharmacy Drug Pre-Service Medical Review Program

In response to Provider concerns regarding unique billing requirements and retrospective medical review, Anthem Blue Cross offers a pre-service or prior authorization Utilization Management (UM) review program. In an effort to speed payment to Providers UM review is performed by our Specialty Pharmacy Medical Management (SPMM) unit, comprising of technicians, nurses and physicians. Please note that for HMO Covered Individuals, the assigned Participating Medical Group performs the UM review.

Detailed information about the Specialty Pharmacy Medical Management Pre-Service Program, including request forms, can be accessed online by clicking here. Or you may go to the anthem.com/ca website, click on "Providers," scroll down to the Learn More (left side) section, and select "Prior Authorization List"). At the top of this list, you will see a blue highlighted link called "Specialty Pharmacy Website," click this link. To request pre-service medical review for a specialty drug, Providers should complete the appropriate form, available through the link described above, and fax the Pre-Service Medical Request form to 866-408-7195 or call SPMM directly at 866-580-5293.

Physical, Occupational and Speech Therapy

Introduction 2
Billing Requirements 2
Reimbursement 2

Introduction

This section outlines general billing guidelines for all Anthem Blue Cross commercial plans and senior plans including, but not limited to, Anthem Blue Cross Preferred Provider Organization (PPO) or Anthem Blue Cross Health Maintenance Organization (HMO), Medicare Advantage, and Exchanges or Covered California, and identifies useful coding in conjunction with the *Claims Submission* section in this Manual to help therapy Providers submit claims to Anthem Blue Cross. Please refer to the *Claims Submission* and *Reimbursement* sections of this Manual for more information about Electronic Data Interchange (EDI), Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA).

Billing Requirements

The following information outlines billing requirements for therapy services.

1. Be sure to complete all of the necessary information on the *CMS-1500 Claim Form*:
   a) Check the Anthem Blue Cross Member's ID card for the appropriate mailing address.
   b) When submitting a claim for an Anthem Blue Cross Member whose policy requires preauthorization, attach the authorization form, or include the authorization number in locator 23 (loop 2300).
   c) Provide the appropriate *Current Procedural Terminology* (CPT) in locator 24D for each procedure billed. Refer to the current CPT book for appropriate coding.
   d) Provide the referring physician's name and Type 1 National Provider Identifier (NPI) number in locator 17 (loop 2310A).
   e) Provide the name and address of the facility where services are rendered in locator 32 (loop 2310AA). Do not use a P.O. Box number.
   f) Provide the name, remit address and Type 2 NPI of the billing group/organization in locator 33 (loop 2310AB).
   g) Provide the rendering practitioner's name, taxonomy code and Type 1 NPI in locator 41 (loop 2310B). Please do not provide this information in locator 43 (loop 2420A).
   h) If the rendering practitioner is a physical therapy assistant, please provide the name, taxonomy code and Type 1 NPI of the supervising physical therapist in locator 41 (loop 2310B). If a physical therapy assistant is identified in locator 41 (loop 2310B) claims will be delayed and may be rejected.
   i) Name and Type 1 NPI for a physical therapy assistant may be provided in locator 43 (loop 2420A).

Reimbursement

Please refer to Exhibit A of the Agreement for reimbursement. To determine if specific codes are covered and the reimbursement for a code go to ProviderAccess® at anthem.com/ca.

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 Provider Care at the number of the Member's health ID card to confirm benefits and eligibility.

Service Area	Telephone
Behavioral Health Care Management/Utilization Review	800-274-7767
Mailing Address	**Fax**
Anthem Blue Cross Behavioral Health Attn: Care Management P.O. Box 600188 San Diego, CA 92160	866-582-2287

Submitting Changes

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Introduction

This section provides information on how to submit Provider demographic changes to Anthem Blue Cross for participating professional Providers. There are specific requirements depending on the type of Provider and contractual relationship.

Ancillary Professional Provider Changes

The following are the requirements to submit changes for ancillary Providers, with direct contracts with Anthem Blue Cross, that submit claims on a *CMS-1500 Form*, ambulance, audiology, hearing aid dispensers, durable medical equipment (DME), free-standing home infusion therapy (HIT) Providers, laboratories, and physical, occupational and speech therapists.

Change requests must be submitted in writing, on company letterhead, and submitted directly to Provider Data Management. All requests must include the following information:

1. Current date
2. Current information and new information
3. Reason for the change
4. Effective date of change
5. Tax identification number (TIN) or Employer Identification Number (EIN)
6. Signed W-9 form
7. Medicare ID, if applicable
8. License, name on license, and National Provider Identifier (NPI) number for each new license being added or deleted from the TIN
9. Officer level signature (Owner, President, Vice President, CEO, CFO, Treasurer, etc.)
10. Contact phone number in the event of questions

Types of changes include:

- Check EOB address changes
- Telephone and fax number changes
- NPI additions and changes
- TIN changes
- Facility additions, deletions or address changes
- Facility name change
- Medicare ID change
- Adding or deleting a license (therapist or audiologist) from a tax ID

It takes a minimum of fifteen (15) business days to make a change and changes are not retroactive.

Submit all completed requests directly to Provider Data Management via email ProviderDatabaseAnthem@anthem.com or fax to 818-234-2836.

Behavioral Health Professional Provider Changes

In order to keep Provider directory information and Anthem Blue Cross records up to date, participating practitioners must notify Anthem Blue Cross of practice changes within 30 calendar days of the change. It takes a minimum of fifteen (15) business days to make a change and changes are not retroactive.

All completed requests need to be submitted directly to Provider Data Management via email ProviderDatabaseAnthem@anthem.com or fax to 818-234-2836.

Notification must be in writing, signed and dated by the participating practitioner. Please see below the types of changes and how to keep your records up to date.

Practice Update Form

Anthem Blue Cross offers the Practice Update Form, which may be completed to change the following information:

- Email address
- Practice address
- Mailing address
- Phone and fax number
- Open or closed practice status
- Tax Identification Number* (TIN)
- National Provider Identifier

The Practice Update Form is located online or in the *Exhibits* section of this Manual. Complete the form and return it via mail or fax using the contact information listed at the top of the form. Include specific addresses, TINs and telephone numbers for each specific location. Incomplete or unsigned forms cannot be processed.

*For TIN changes, a *Request for Tax Payer Identification Form* (W-9) must be included. Visit irs.gov to obtain a W-9 form.

Practice Profile Form

Participating practitioners will use the *Practice Profile* form when updating:

- Self-reported areas of expertise
- Open or closed practice status
- Age ranges treated
- Additional languages spoken
- Provider ethnicity (optional)

The *Practice Profile* form is located online at anthem.com/ca > Providers > Enter > Behavioral Health Provider Resources > Forms > Practice Profile or in the *Exhibits* section of this Manual.

Open or Closed Practice Updates

Participating practitioners shall provide prompt written notice of a closed practice by utilizing a *Practice Profile*, a *Practice Update Form* or by written notice. Both forms are available online at anthem.com/ca > Providers > Enter > Behavioral Health Provider Resources > Forms > Practice Profile or in the *Exhibits* section of this Manual.

Notification Requirements

Notification of updates must be submitted in writing and within 30 calendar days of the change. Anthem Blue Cross prefers to receive completed Anthem Blue Cross Provider Update Forms. However, if a form is not offered for the particular update or is not available to the participating practitioner, Anthem Blue Cross will accept written notice to include the participating practitioner's:

- Office letterhead or address and phone contact information
- Signature and date
- Clear instructions including the old information and the new information
- An effective date of change, if applicable

Submit all completed requests directly to Provider Data Management via email ProviderDatabaseAnthem@anthem.com or fax to 818-234-2836.

Professional Provider Changes

Change requests must be submitted in writing, on company letterhead, and submitted directly to Provider Data Management via email ProviderDatabaseAnthem@anthem.com or fax to 818-234-2836. All requests must be signed by the Provider and include the following information:

1. Nature of the request
2. TIN
3. Effective date of change (and "end" date of old information)
4. W-9 is required for tax ID change or tax ID name change, and Remit address changes; Visit irs.gov to obtain a W-9 form.
5. Check/EOB and physical address location including phone number(s) and fax number, if available
6. NOTE: Correspondence must be signed by the Provider or billing department

Types of Adds, Changes and Terminations include:

- TIN
- Tax ID name (DBA) – requires an Amendment form for participating CA Providers
- Provider organization name – requires an Amendment form for participating CA Providers
- Check/EOB, mailing and/or physical practice address
- Phone and fax numbers
- NPIs

- Adding or terminating Providers to/from a Provider organization
- Participating status – application and termination from the network

It takes approximately 15 business days to complete an update request.

Contact Information

Send requests directly to Provider Data Management:

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

Workers' Compensation Providers

Change requests specifically related to your practice participation in the Workers' Compensation Network should be sent directly to: AWCCustomerrelations@anthem.com

All changes should be on practice letterhead, signed and may include the following changes:

- Practice is no longer accepting new Injured Workers
- Practice will only accept Injured Workers based on professional referral
- Specific practice location no longer treats Injured Workers

Providers Contracted Through Vendors

The following are requirements to submit changes for professional Providers contracted through vendors.

Acupuncturists and Chiropractors

! Acupuncturists and Chiropractors are contracted directly through American Specialty Health (ASH).

All changes must be submitted directly through ASH. The contact information is listed in the table on the following page.

Area	Telephone Number	Contact
Acupuncture	888-226-8879	Email: service@ashn.com Mailing Address: American Specialty Health P.O. Box 509001 San Diego, CA 92150-9001
Chiropractic	800-972-4226	

Optometrists

All changes must be submitted directly through Vision Service Plan (VSP). Contact them at

P rovider Services Support: 800-615-1883

Reimbursement

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Introduction

This section provides information on pricing and reimbursement. The discussion on reimbursement includes other payment sources, such as third-party liability and coordination of benefits. *Reimbursement Reports* [i.e., *Explanation of Benefits (EOB)*] and the procedures seeking excess claim payments, referred to as overpayment and recovery, are also addressed.

How Payments are Determined

Refer to your Anthem Blue Cross Agreement for information on the payment schedule. Participating Providers can access their payment schedule through ProviderAccess®. Log in at https://provider2.anthem.com/wps/portal/ebpmybcc.

The Anthem Blue Cross reimbursement amount is based on the maximum allowable or the Provider's billed amount, whichever is less. For Workers' Compensation, reimbursement is based on the lesser of the Provider's billed amount for Covered Services or the negotiated rate, or a discount off the California Division of Workers' Compensation Official Medical Fee Schedule (OMFS), if applicable. Reimbursement for Workers' Compensation will not exceed the OMFS maximum value. The Provider rate shall represent payment in full to Provider for Covered Services for compensable medical care.

The participating Provider's total reimbursement is the combination of the insurance carrier's payment, the Member's coinsurance or copayment amounts and/or applicable deductibles. The total reimbursement will not exceed the maximum allowable rates indicated in the payment schedule. Since there are different benefit plans, not all copayment, coinsurance or deductible amounts will be the same. Participating Providers that have questions about how a specific payment was calculated should call the appropriate Customer Service number on the Member's ID card or the insurance carrier. Keep a photocopy of the Member's current ID card (front and back) in the Member's file for reference.

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

1. Copayments, coinsurance and deductible amounts required by the Member's Anthem Blue Cross PPO 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).
2. Medical services that are not medically necessary, but agreed to by the Member in advance, in writing, on a waiver form approved by Anthem Blue Cross. The Provider's office must call and receive a denial before the services are rendered. A general waiver is not sufficient. It must be clear to the Member the services have been denied and will not be paid. A sample of the *Covered Individual (Patient) Responsibility Agreement* can be found in the *Exhibits* section of this Manual.
3. Services not covered by the Member's Benefit Agreement and agreed to, in writing, by the Member in advance of services being rendered. Rates billed by the Provider will be in accordance with the maximum allowable rate as established in the Payment Schedule, unless

the Member specifically agrees in writing to alternate rates for non-Covered Services. A sample of the *Covered Individual (Patient) Responsibility Agreement* can be found in the *Exhibits* section of this Manual.

4. Services for Workers' Compensation compensable medical care are paid by Plan (Other Payor). The injured worker may not be balanced billed.

The Provider 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 *Covered Individual (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 physician 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.

Contracted pricing, formerly known as Prudent Buyer pricing, has been enhanced. There is no monthly maximum for the number of *Current Procedural Terminology* (CPT) and *Healthcare Common Procedure Coding System* (HCPCS) codes that can be priced online using ProviderAccess. Pricing is also available for ancillary, Medicaid, Healthy Families, Behavioral Health, Select Network and Physician Partnership Network Providers. For more information about online contracted pricing, refer to the *ProviderAccess* section of this Manual.

Note: Contracted pricing is only available for services allowed by your contract with Anthem Blue Cross.

If you bill under more than one tax identification number (TIN), then you must select one from a drop-down window when using *ProviderAccess*. You will also be prompted to enter a ZIP code. If you bill for more than one region of the state, you must enter a ZIP code to receive proper regional pricing.

To access *ProviderAccess*, simply log in to https://provider2.anthem.com/wps/portal/ebpmybcc

If you do not have Internet access, a pricing form can be mailed or faxed to Anthem Blue Cross with all of the CPT codes of the practice. The Network Relations department completes the form and documents the maximum Anthem Blue Cross allowable amount for each CPT code. The *Request for Network Provider Pricing* is available in the *Exhibits* section of this Manual.

Coordination of Benefits (COB)

The coordination of benefits (COB) determines responsibility for paying eligible expenses among insurers providing group coverage to the Member. In a COB situation where Anthem Blue Cross is a secondary payer, Anthem Blue Cross pays in accordance with *Title 10* of the *California Code of Regulations, Section 1300.67.13*, or applicable state or federal regulations. COB refers to how Anthem Blue Cross ensures Members receive full benefits, and how double payment for services is prevented when a Member has coverage from two or more sources. The Member's contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

Anthem Blue Cross and the Provider agree to accept the COB rules provided in *Title 10* of the *California Code of Regulations, Section 1300.67.13*. If Anthem Blue Cross, under the applicable Member Benefit Agreement, is a primary payer, Anthem Blue Cross will pay the amounts due under the Agreement, reduced as provided therein. The Anthem Blue Cross payment will not exceed the maximum allowable amount, total charges, or the Member's responsibility for deductibles and copayments.

Be sure to submit an EOB from the primary insurance carrier when you submit the claim for payment to a secondary payor. The following is a summary of the COB rules as indicated in the participating Provider's Anthem Blue Cross Agreement and guidelines developed by the Department of Managed Health Care (DMHC).

If Anthem Blue Cross, under the applicable Member Benefit Agreement, is other than primary, or is otherwise secondary to any other coverage (including, but not limited to, Medicare), Anthem Blue Cross will pay the lesser of the amounts, which, when added to the amounts received by the Provider from all other sources, pursuant to applicable COB rules, shall not exceed 100 percent of the amount required by the Agreement, or the Member's liability for deductibles and copayments.

In cases where the Provider accepts a Medicare assignment and: (i) Medicare is the primary payer under the COB rules referenced in 6.4; (ii) Anthem Blue Cross covers all, or a portion of, Medicare cost-sharing amounts; and (iii) medical services are covered by Medicare, when permitted under the applicable Benefit Agreement, the contracted maximum allowable amount will equal the Medicare allowable amount.

Coordination of Benefits for FEP

In certain circumstances when FEP is the secondary payor and there is no adverse effect on the Covered Individual, we may take advantage of any Provider discount arrangements the primary payor may have and only make up the difference between the primary plan's payment and the amount the Provider has agreed to accept as payment in full from the primary plan.

Prime Carrier Rule

Responsibility for benefits payment is determined by using the *Rules Establishing the Order of Benefits Determination*, which were developed by the DMHC, and are incorporated into all appropriate Anthem Blue Cross group contracts. These rules determine the payment responsibilities between Anthem Blue Cross and other applicable group insurers by establishing which insurer is the prime carrier and which is the secondary carrier. This is known as the Prime Carrier Rule.

To establish a Member's prime carrier, the following rules are used:

1. In determining the length of time a Member has been covered under a plan, the Member's first effective date under that plan is used. If a group has changed plans, the plan is considered continuous as long as a lapse in coverage of more than 24 hours has not occurred. Neither changes in benefits and insurance carriers, nor changes from one type of coverage to another (as from a single-employer to a multiple-employer plan, etc.) constitute a new plan.

If the Member's effective date of coverage is, for any reason, after the group's effective date, and if specific information verifying the Member's original effective date is not available, the Member's available effective date under that plan is used.

If the Member's effective date of coverage under a given plan is the same as the group's effective date, then the insurance carrier requests that the group furnish the date the Member first became covered under the earliest of any prior plans the group may have had. If the date is not readily available, the date the individual first became a Member of the group is used to determine how long the coverage has been in force.

2. Some group plans contain an "excess" coverage provision, under which their benefits become available only after all other carriers have provided benefits.
3. The Prime Carrier Rule does not apply to:
   a. Nongroup policies
   b. Automobile insurance policies
   c. Medicaid
   d. TRICARE (formerly CHAMPUS)
4. If one group contract contains a COB provision and one does not, the contract without the COB provision is prime.
5. If both group contracts contain a COB provision, use the first of the following rules that applies to determine which plan is primary:
   a. The plan which covers the person as a Subscriber is primary over the plan which covers the person as a dependent, except that, if the person is also a Medicare beneficiary and as a result of federal Medicare regulations, Medicare is (i) secondary to the plan covering the person as a dependent and (ii) primary to the plan covering the person as a Subscriber (e.g., a retired employee), then the plan covering the person as a dependent is primary over the plan covering that person as a Subscriber. In this situation, the plan covering the person as a dependent is prime, Medicare is secondary and the plan covering the person as a Subscriber is third.
   b. Except for cases of a dependent child whose parents are separated or divorced, the plan which covers the child as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a calendar year, is primary over a plan which covers the child as a dependent of a person whose date of birth, excluding year of birth, occurs later in a calendar year (this is the Birthday Rule). If one plan does not follow the Birthday Rule, the provision of that plan will determine the prime carrier.
   c. Except as provided in subparagraph (e), in the case of a child whose parents are separated or divorced and the parent with custody of the child has not remarried, the plan which covers the child as a dependent of the parent with custody of the child will be prime and the plan which covers the child as a dependent of the parent without custody is secondary.
   d. Except as provided in subparagraph (e), in the case of a dependent child whose parents are divorced and the parent with custody of the child has remarried, the order of benefits is as follows: (1) The plan which covers the child as a dependent of the parent with custody is prime, (2) the plan which covers that child as a dependent of the stepparent is second and (3) the plan which covers that child as a dependent of the parent without custody is third.

e. In the case of a dependent child whose parents are separated or divorced, where there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expenses with respect to the child, then, notwithstanding subparagraphs (c) and (d) above, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility is primary over any other plan which covers the child as a dependent child.

f. Except as provided in subparagraph (g), the benefits of a plan covering the person as a laid-off or retired employee, or dependent of such person, shall be determined after the benefits of any other plan covering such person as an employee, other than a laid-off or retired employee, or dependent of such person. This rule applies when the person is either the Subscriber on both plans or a dependent under both plans.

g. If either plan does not have a provision regarding laid-off or retired employees, which results in each plan determining that it is the secondary plan, then the rule under subparagraph (f) shall not apply.

h. If a person whose coverage is provided under a right of continuation pursuant to federal or state law also is covered under another plan, the following shall be the order of benefit determination: (1) the benefits of a plan covering the person as a Subscriber, or as the Subscriber's dependent; (2) the benefits under continuation coverage. This rule applies when the person is either the Subscriber on both plans or a dependent under both plans. If the other plan does not have this rule regarding continuation coverage, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

i. When these rules do not establish an order of benefit determination, the plan that has covered the person for the longer period of time shall be primary over the plan that has covered the person for the shorter period of time.

Order of Benefits for Dependent Children

Mother and Father	Prime	Secondary	Tertiary
Married or never married	Parent with birthday earlier in calendar year	Parent with birthday later in calendar year	N/A
Married or never married – both have the same birthday	Plan in effect the longer period of time	Plan in effect the shorter period of time	N/A
Married or never married – both have the same birthday and the same effective date	Charges are split 50/50 between the two plans N		/A
Separated or divorced with joint custody, and no court decree	Parent with birthday earlier in the calendar year	Parent with birthday later in the calendar year	N/A

Mother and Father	Prime	Secondary	Tertiary
establishing coverage responsibility			
Married, never married, separated or divorced – only one plan has Birthday Rule	COB provision of plan without the Birthday Rule determines which plan is the prime carrier	N/A	N/A
Separated or divorced – parent with custody is not remarried	Parent with custody	Parent without custody	Spouse of parent without custody
Divorced – parent with custody has remarried	Parent with custody	Stepparent	Parent without custody
Separated or divorced – with court decree	Parent with health care coverage responsibility	Any other plan covering the child as a dependent	N/A

TRICARE/CHAMPVA

Anthem Blue Cross is the prime carrier with responsibility for first payment when the Member is also eligible for TRICARE (formerly CHAMPUS) or the Civilian Health and Medical Program of the Veterans Administration.

Medicare Program: COBRA and OBRA*

The following are federal laws that direct the primary and secondary relationship between Medicare and Anthem Blue Cross. Note: If COBRA laws change, Anthem Blue Cross and the Provider must comply, as specified in the amendments.

1. Consolidated Omnibus Budget Reconciliation or Gramm-Rudman Act (COBRA*) – This law expanded the *Deficit Reduction Act (DEFRA)*, by removing age-limit restrictions and making group insurance prime for all actively employed individuals and their spouses, regardless of age.
2. Omnibus Budget Reconciliation Act (OBRA) – This law, an amendment to COBRA*, established that group insurance is prime for any Medicare-covered disabled beneficiary under age 65 who is covered as an active employee or dependent under a group health plan. The exceptions to this are beneficiaries with end-stage renal disease (ESRD).

   Medicare is the primary payer for disabled beneficiaries who are treated as employees by their employers, but who are not actually working. The employer has to sign a form certifying that the

disabled beneficiary is not working. Anthem Blue Cross must pay until the Medicare carrier receives the certification.

A disabled individual is considered an active employee if:

a. The disabled individual is employed under Medicare's trial work program or extended period of eligibility.
b. The employer is paying Federal Insurance Contributions Act (FICA) tax for the disabled individual.

COBRA* applies to groups with 20 or more employees, while OBRA applies to groups with 100 or more employees. Retiree groups are not affected.

Health professionals should assume that Anthem Blue Cross is the prime carrier and Medicare is the second carrier for all active employees and their spouses.

Under COBRA* continuation coverage, if the Member has Medicare and enrolls in COBRA*, Medicare is prime to COBRA* coverage. If the Member has COBRA* coverage and enrolls in Medicare, COBRA* coverage may be subject to termination.

Retiree groups are not affected by this stipulation, so, in these cases, Medicare is the prime carrier. This is why retiree contracts either contain non-duplication of Medicare clauses or offer supplemental coverage.

In all cases, it is up to the employer to notify Anthem Blue Cross of its Members' status.

Medicare is the prime carrier under the following circumstances:

1. The Member or spouse makes a written request to the group to have Medicare as the prime carrier when COBRA* is involved. Medicare cannot be the prime carrier with OBRA, except for ESRD patients.
2. The Member or spouse has ESRD (after the 30-month coordination period).
3. The employer group does not meet the compliance requirements; for COBRA*, this is an employer group with more than 20 employees; for OBRA, this is an employer group with more than 100 employees. If the employer group does not meet these requirements, Medicare is the prime carrier. Anthem Blue Cross can offer non-duplication of Medicare benefits or Medicare supplemental contracts.
4. If the employer group is a multiemployer trust (MET) and any one of the employers meets the compliance requirements, the entire group is considered to have met the requirements.

   Exception to MET: If the MET can identify Members as employees of a group with less than 20 employees, Medicare is the prime carrier for those individuals. If it cannot identify them, Anthem Blue Cross is the prime carrier. It is the employer group's responsibility to notify Anthem Blue Cross.
5. The employer group covers retirees only.

*COBRA, as used in this section, does not refer to group coverage continuation.

End-Stage Renal Disease Group Contracts

ESRD is a kidney disease or malfunction that is permanent (irreversible), and requires a regular course of dialysis or a kidney transplant for the patient to maintain life. Renal dialysis mechanically performs the kidney's function of separating and removing undesirable substances from the blood.

A patient who is under age 65 and receives renal dialysis for longer than three months can be eligible for Medicare benefits, regardless of age. The individual must apply for these benefits.

Under the *Balanced Budget Act of 1997*, group insurance is primary and Medicare is the secondary payor for the initial 30 months of treatment following Medicare eligibility for any Member under the age of 65 who is covered as a current or former employee, or dependent, under a group health plan, and who is eligible for Medicare solely on the basis of being an ESRD patient. This is called a coordination period. It is further extended to 33 months if the three-month waiting period for Medicare eligibility applies. This is true for all groups, regardless of size.

ESRD Benefit Determination for Group Members

If	Then
Member is under age 65, diagnosed with ESRD, and eligible for Medicare based solely on ESRD	Anthem Blue Cross is the prime carrier for 30 months after any applicable waiting period.
Member is under age 65, diagnosed with ESRD, and currently eligible for Medicare because of another disability; group has over 100 employees	Group is the prime carrier during the 30-month coordination period. After the coordination period, Medicare becomes primary.
Member is under age 65, diagnosed with ESRD, and currently eligible for Medicare because of another disability; group has less than 100 employees	Medicare is the prime carrier. The group also has less than 100 employees and, therefore, is not subject to OBRA for the disability.
Member is under age 65 and diagnosed with ESRD; group has less than 20 employees	Anthem Blue Cross is the prime carrier for 30 months after any applicable waiting period. There is no group size requirement for ESRD.
Member is over age 65 and diagnosed with ESRD; group has more than 100 employees	Anthem Blue Cross is the prime carrier during the 30-month coordination period; after the waiting period, Medicare becomes the prime carrier.
Member is over age 65, retired, on a retiree group, and diagnosed with ESRD	Medicare is the prime carrier.
Member is under age 65, diagnosed with ESRD, in any size group, and then becomes eligible for Medicare because of another disability	Anthem Blue Cross is the prime carrier during the 30-month coordination period; after the waiting period, Medicare becomes the prime carrier.

If	Then
Member is over age 65, on an active group plan, enrolled in Medicare due to age, and is diagnosed with ESRD; employer has more than 20 employees	The group meets the working-aged rule requirement. Group plan is primary. Medicare is secondary. Because a second eligibility event occurs that is due to ESRD, Medicare will become primary 30 months from the ESRD entitlement date, without regard to the second reason for Medicare eligibility.
Member is over 65, on an active group plan, enrolled in Medicare due to age, and is diagnosed with ESRD; employer has less than 20 employees	The group does not meet the working-aged rule requirement. Medicare is primary. Group plan is secondary. In this particular situation, the subsequently occurring second reason for Medicare eligibility has no effect. Medicare continues to be primary.

Third-Party Liability

Any illness, injury or other condition for which another person or entity is liable or legally responsible, including for costs associated with the Anthem Blue Cross Member's condition, is considered third-party liability. Anthem Blue Cross may be entitled to reimbursement from Members receiving settlements, judgment awards or other third-party payments.

When a third party may be liable, Providers should notify the Anthem Blue Cross Third-Party Liability department by calling Meridian at 800-645-9785 or visiting online at www.meridianresource.com/subro.html

Backup Withholding

The Internal Revenue Service (IRS) requires that we withhold 28 percent of the Anthem Blue Cross allowable amount, less any benefit reductions, in tax, called Federal Backup Withholding, if a payee does not furnish us with the correct name and tax identification number (TIN) combination, as shown on the records of the IRS or Social Security Administration (SSA). A payee includes any Provider. Additionally, if a payment is mailed to a California address and the payee is subject to 28 percent Federal Backup Withholding, an additional 7 percent will be withheld per Franchise Tax board Regulations. See https://www.ftb.ca.gov/ for additional information.

** The withhold amount is 28 percent of the Anthem Blue Cross PPO allowable amount, less any benefit reductions.

Generally, backup withholding begins for payees who:

1. Have been notified by Anthem Blue Cross that their name and/or TIN does not match the name and/or TIN on record with the IRS or SSA; and
2. Do not respond by submitting a completed and signed *W-9* form within 30 business days from the date noted on the solicitation.

Should you receive this solicitation, complete the W-9 form and promptly mail it to the 1099 Tax Reporting department at the following address:

Anthem, Inc.
1099 Tax Reporting
120 S. Via Merida, CAT201-C005
Thousand Oaks, CA 91362

In addition, it is important to note that any amounts withheld from your account, under the federal tax rules discussed above, may not be charged to, or reimbursed from, your patients.

Should you have any questions, call the 1099 Tax Reporting department at 888-246-4893. You may contact the 1099 Tax Reporting department for inquiries related to your 1099 Form. Instructions for Form 1099-MISC are available at irs.gov.

Explanation of Benefits (EOB)

The Anthem Blue Cross *Explanation of Benefits* (EOB) is a reimbursement report that consists of detail-line information and a payment summary. EOBs are issued either electronically or generated from the Anthem Blue Cross claims processing system in hard copy (paper) format. You can also initiate a Remittance Advice (RA) inquiry for a professional EOB by clicking on the *Claims* tab in ProviderAccess®. For more information about Online Provider Remits, go to anthem.com/ca > Providers > Provider Home > Provider Network Education > Quick Reference Tools and Job Aids.

Sample of the following EOB is included in the *Exhibits* section of the Manual for reference:

- *Participating Provider EOB*

The Exhibit illustrates Provider and Member EOBs that contain the following elements:

First Section: Header Information	
Provider Name	Name of Provider
Mailing Address	Provider billing address
Issue Date	Date the EOB was issued
Page Number	Current page number; page “001” is the check.
Sequence Number	All EOBs have sequential numbers. The number includes the year and the EOB number within the year. The sequence restarts each calendar year.
Provider ID	Provider tax ID number or Social Security Number; this is a nine-digit field.
Anthem Blue Cross Provider	Y = Yes or N = No
Foundation Physician	Y = Yes or N = No

Second Section: Detail Information This information is organized alphabetically in the EOB according to the patient's last name, then by the claim identification number specific to that patient, and then by the line item of each claim.	
Patient Name	Name of the patient
ID Number	Patient's Anthem Blue Cross ID number
Group Number	Patient's Anthem Blue Cross group number
Claim ID	The number assigned to the claim by Anthem Blue Cross
Claim Received Date	The date the claim was received (for original claims only)
Service Date(s)	The start and end dates of service
Procedure Number	The CPT/HCPCS procedure code and modifier, if any
Units of Service	Units of occurrence, if applicable
Billed Amount	The amount billed for the service period
Allowed Amount	Negotiated Anthem Blue Cross PPO fee schedule allowance for the code that is used to pay the claim
Not Allowed Amount	The amount by which the Billed Amount exceeds the Allowed Amount; a reason code is given with the explanation in the "Final Section" below
Deductible Amount	The amount applied to the patient's deductible
Coinsurance/Copayment Amount	The amount of the patient's coinsurance that is determined by the Member's contract benefits
Anthem Blue Cross Payment	The allowed amount, less applicable deductible, coinsurance and copayment amounts
Adjustment/Deductible Information	This line following the claim detail indicates if the claim is an adjustment. If so, it cross-references the EOB sequence number of the original claim determination. This line also indicates the individual Member's deductible amount and the family deductible that has been applied to date.
Inquiries	Telephone number of the Anthem Blue Cross division that handled the claim

Final Section: Messages
This area lists the English language description of any reason codes appearing in the “Not Allowed Amount” column.

Payment Summary Information

This final page of the EOB reflects a summary of the transactions for the EOB date. It is possible to see both positive and negative amounts in most categories.

Claims Payment/Adjustments

This section includes a summary of all of the claims and adjustments that are detailed in the previous page(s). The subtotal amount indicates the amount Anthem Blue Cross is paying for claims for a particular day.

Deferred Claims Adjustment Withhold

Anthem Blue Cross notifies Providers of any adjustments, including overpayments, on the EOB. The amount is reflected in the “Claims Payment/Adjustments” section of the payment summary.

The “Deferred Claims Adjustment Withhold” section includes a list of overpayments that are being deducted from the current payment. Each claim is itemized, including the Subscriber’s last name, patient account number, the date of the original EOB, Provider’s TIN and the sequence number of the original EOB.

Refunds

Information appears in the “Refund” section when Anthem Blue Cross is refunding money to the Provider for any reason.

Check Amount

If the sum of payments and withhold funds results in payment to the Provider, the payment appears as the check amount. If there is no payment to the Provider, zeros are shown and no check is issued.

A negative amount means the Provider has a negative claims balance. The system does not issue a check, and the negative amount appears as the “Deferred Adjustments Amount Due Anthem Blue Cross.”

Overpayment Recovery Procedure

Anthem Blue Cross seeks recovery of all excess claim payments from the payee to whom the benefit check was made payable.

If you dispute or have any questions regarding an overpayment recovery, contact the telephone number listed on the overpayment letter.

Or you may mail substantiating documentation related to your dispute to the address listed on the overpayment recovery letter.

1. Day 1: Anthem Blue Cross identifies overpayment.
2. Day 2-5 Letter number one is sent.
   - If the Provider believes that the overpayment was created in error, the Provider should contact Anthem Blue Cross in writing.
   - For a reevaluation of the claim, send your correspondence to the address indicated on the overpayment notification.

   If Anthem Blue Cross does not hear from the Provider or receive payment within 30 days, the following action is taken:
3. Day 30: Letter number two is sent for claims that have processed through the Checkwrite system. Claims processing outside Checkwrite system will not generate letter at day 30.
   - This is a final request for payment.
   - If payment is not received within 15 days, recovery of the overpayment amount will be taken out of future claim payments.
4. Day 45-49: Anthem Blue Cross will deduct overpayment amounts from future claim payments.
5. Day 60: In cases where Anthem Blue Cross determines that deducting from claim payments is not feasible, letter number three is sent for claims processed through the Checkwrite system. Claims processing outside Checkwrite system will not generate letter at day 60.
6. Day 90: Final letter request is sent if no payment has been received.
7. Day 120: If a check for the overpayment has not been received, the overpayment is referred to a collection service.

Note: These are calendar days, not business days.

If you have any questions regarding overpayment recovery, contact Anthem Blue Cross Customer Service (see the *Directory of Services* section of this Manual for the appropriate telephone number).

Payment Received in Error, Overpayment or Duplicate (for submission of overpayment checks only). DO NOT submit additional documentation, if you are disputing the overpayment refund request. See above for Overpayment Recovery Procedure. In addition, follow the guidelines provided in the Information for Contracting Providers – Dispute Resolution Process in the *Dispute Resolution Process for Contracted Providers* section. If you have any questions regarding the incorrect payment (i.e. amount of overpayment), call the Customer Service number on the EOB.

Follow the steps below when you receive a payment from Anthem Blue Cross or Other Payor that you believe is (a) for the wrong patient; (b) an overpayment; or (c) a duplicate payment. If you agree an overpayment has occurred, or No Contest, you may follow these guidelines:

1. Determine whether the check is for one or more Members. If the check covers more than one Member, cash it and issue a refund check to Anthem Blue Cross or to the Other Payor for the refund amount. If the payment is for one Member only, it is not necessary to cash the check. You may return the uncashed check to Anthem Blue Cross using the address below.
2. Include a copy of the EOB and a written explanation with the returned check or refund check.

3. Send the above information to:

Attention: Financial Operations
P.O. Box 92490
Cleveland, OH 44193

Preventable Adverse Events (PAEs) Policy

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

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

Whenever any of the events described in the grid below occur with respect to a Covered Individual, 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 Present on Admission (POA) indicators (as defined by CMS) must be populated on all inpatient acute care Facility claims.

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

Providers and Facilities (excluding Inpatient 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 Covered Individual, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan or the Covered Individual for such events. If Provider or Facility receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, Providers and Facilities shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Covered Individual, Providers and 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.

Medical Management Programs

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Introduction

This section addresses Utilization Management (UM) processes and the integration of Case Management (CM) services with Anthem Blue Cross.

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 Covered Individual advocacy that evaluates, develops, implements, and coordinates options, resources and services. It includes working one-on-one with Covered Individuals, their families and other members of the interdisciplinary care team, using behavioral change science to promote engagement. Covered Individuals 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

The following definitions supplement those provided in Article II of the *Prudent Buyer Plan Participating Physician Agreement:*

Behavioral Health Levels of Care. Anthem Blue Cross has defined five levels of care, which are listed below:

- Acute Level of Care

  Acute care describes the high-level of skilled psychiatric and chemical dependency (substance abuse) services in a Facility. Acute Facility means a free-standing psychiatric hospital, designated psychiatric unit of a general acute hospital, or a detoxification unit in a hospital licensed by the State of California to provide 24-hour medical and nursing care.
- Intensive Outpatient Programs Level of Care

  Intensive outpatient programs are defined as 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. These encounters are usually comprised of coordinated and integrated multi-disciplinary services. The range of services is designed to address a mental or chemical (substance) use disorder and could include group, individual, family, or multi-family group psychotherapy, psychoeducational services and adjunctive services such as medical monitoring [although treatment for chemical (substance) related disorders typically includes involvement in an anonymous-based self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time, as described here, excludes time spent in anonymous-based self-help programs, which are offered by community volunteers without charge]. Intensive Outpatient Programs must be supervised by a licensed behavioral health care professional.

- Outpatient Professional Treatment Level of Care

  Outpatient professional treatment is typically individual, family, and/or group psychotherapy and consultative service ranging in duration from 15 minutes (e.g., medication check) to 50 minutes (e.g., individual, conjoint or family psychotherapy) up to two hours (e.g. group psychotherapy) per encounter.

- Partial Hospital and Day Treatment Level of Care

  Partial hospital or day treatment programs are defined as structured and medically supervised day treatment programs. Program services are provided for no less than six hours a day, but usually no more than eight hours a day, and at least five days per week. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital, except that the patient is in the program less than 24 hours per day. The patient is not considered a resident in the program. The range of services offered is designed to address a behavioral health and/or substance related disorder through an individualized treatment plan provided by a coordinated, multi-disciplinary treatment team.

- Subacute or Residential Level of Care

  Subacute care is residential, intermediate level, skilled care, usually provided in a Residential Treatment Center or Inpatient Treatment Facility. Rehabilitation treatment for alcohol and chemical dependency (substance abuse) and residential treatment for adolescents with psychiatric conditions are included in this level of care. Settings that are eligible for this level of care are licensed to provide psychiatric or rehabilitative treatment at the residential intermediate level or an intermediate care Facility (ICF).

*Please refer to the Anthem Blue Cross Behavioral Health Clinical UM Guidelines, in their entirety for levels of care and intensity of services criteria. This is located at anthem.com/ca > Providers > Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements > Medical Policies and Clinical UM Guidelines (for Local Plan Members) > Behavioral Health Clinical UM Guidelines. Access to the information is also available in the *Links* section of this Manual.

Business Day. Monday through Friday, excluding legal holidays.

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 Blue Cross medical policy.

Care Coordination Management. Review for Medical Necessity during service delivery including review for transitions of care and discharge planning.

Facility-based Treatment for Mental Disorders, Chemical Dependency and Detoxification. General acute hospital, psychiatric health Facility, chemical dependence recovery hospital, residential treatment center or day treatment program center or other care Facility or outpatient treatment setting.

Notification. The telephonic and written communication to the health care professional(s) and the Covered Individual documenting the medical appropriateness decision, and informing the health care professional and Covered Individual of their rights if they disagree with the decision.

Peer Clinical Reviewer. A health care professional that holds a current license in the same licensure category as the requesting health care professional, is board certified, and 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.

Pre-service Review. Review for Medical Necessity prior to service delivery.

Post-service Review. Review for Medical Necessity after service(s) has been rendered.

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.

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.

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.

UM Intake Representative. Non-clinical staff who obtain non-clinical and structured clinical information by

telephone at the time of the Covered Individual's request for review or service notification.

UM Reference Number. Number given to the health care professional(s) following review for medical appropriateness. This number must be included on the claim for payment when services require review for medical appropriateness.

Utilization Management

Program Overview

Providers and facilities agree to abide by the following Utilization Management (UM) Program requirements in accordance with the terms of the Agreement and the Covered Individual's health benefit plan. Providers and facilities agree to cooperate with Anthem Blue Cross 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 may be required when a service is requested or planned (pre-service review), during the course of care (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 Covered Individual'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 telephone, fax or electronic communication.
- The service is excluded from coverage.
- The Covered Individual is not eligible for coverage when the service is provided.

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

All inpatient medical admissions require UM. UM for inpatient medical services may include but is not limited to: acute hospitalizations, units described as "sub-acute," "step-down" and "skilled nursing Facility;" designated skilled nursing beds/units; comprehensive outpatient rehabilitation facilities; rehabilitation units; inpatient hospice; and sub-acute rehabilitation facilities or transitional living centers. These services are subject to admission review for Medical Necessity, service appropriateness and level of care. In addition, these services require approval from Anthem Blue Cross' UM program.

Non-inpatient medical services may require pre-service review. The list of services requiring pre-service review can be accessed through the Anthem Blue Cross Provider website anthem.com/ca

UM for behavioral health services, inpatient and non-inpatient require pre-service review or care coordination management. Residential and Partial Hospitalization Behavioral Health admission/services require pre-service review. Non-urgent Behavioral Health admission/services require pre-service review (e.g., intensive outpatient, hospitalization or outpatient professional services).

Pre-service Review

*Emergency Behavioral Health/detoxification admissions do not require pre-service review. Please refer to *Care Coordination Management* subsection of this section.

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 Blue Cross UM within twenty-four (24) hours or next business day of a Covered Individual'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 Covered Individual, prior to the planned admission or service. If the service is requested via telephone, the Anthem Blue Cross 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 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 Blue Cross 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, please 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 Covered Individual are notified in writing of the UM reference number, the specific services and dates approved as medically necessary.

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 make best efforts to supply requested information within twenty-four (24) hours of request. Coordination of Care 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, please refer to the peer clinical reviewer process later in this section. Coordination continues until Covered Individual is discharged, or until inpatient care is no longer authorized. Coordination will be conducted on all pre-certified admissions that exceed the initial pre-certified length of stay. The Facility is required to notify Anthem Blue Cross 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 care coordination process, the physician, hospital, Facility, or other health care professional is notified by telephone or fax of the review decision, including level of care and the UM reference number.

When the care coordination process is completed, the physician, hospital, Facility, or other health care professional(s) and Covered Individual are notified in writing of the UM reference number, the specific services and dates approved, as medically necessary.

On-site Program

As part of the UM program, Anthem Blue Cross maintains an On-site Continued Stay Review Program. The Facility UM staff is responsible for following the Covered Individual'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 Blue Cross and provide Anthem Blue Cross with access to Covered Individuals medical records as well as access to the Covered Individuals 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

Post-service Review

Post-service (retrospective) UM review is designed to retrospectively review claims for health services in accordance with the Covered Individual's Health Benefit Plan. Medical records and pertinent information regarding the Covered Individual'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 Blue Cross peer clinical reviewer (PCR). For pre-service and care coordination requests, the Anthem PCR will attempt to contact the treating/ordering physician to obtain the relevant clinical information. The PCR will take into account any specific needs of the Covered Individual or characteristics of the local delivery system, when reviewing the requested service. The service request will be denied if the PCR 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 PCR may render an adverse determination.

For retrospective requests, clinical determination by the Anthem PCR will be based solely on the clinical information submitted.

When the review is completed, the physician, hospital, Facility, or other health care professional(s) and Covered Individual are notified in writing of the Anthem PCR determination.

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

For review of the appeals process, please refer to the *Covered Individual Grievances and Appeals Process* section of this Manual.

Utilization Review Timeframes

! Please see section below (Anthem Blue Cross Prescription Drug Pre-service Review Process) for additional drug related request information.

Urgent pre-service review decisions are made and communicated within 72 hours of receipt of the request. If a Medicare Advantage pre-service request is deemed to be expedited, the decision and notification timeframe is 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 Covered Individuals, physicians, hospitals, Facilities or other health care professionals within two business days of the decision. Specific to Medicare Advantage plans, non-urgent pre-service review decisions are made and communicated within 14 calendar days of the receipt of the request.

When clinical information has been submitted with an initial care coordination review request, the care coordination review 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 clinical information has not been submitted with an initial care coordination review request, the care coordination review can be extended to a maximum of 72 hours.

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

Post-service review decisions are made and communicated in writing to the Covered Individual and the physician, hospital, Facility or other health care professional within 30 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, the Covered Individual and physician, hospital, Facility or other health care professional are notified in writing of the decision timeframe extension. 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
- The type of expert reviewer required if applicable

Participating Provider Responsibilities

The Participating Provider's responsibilities include the following:

1. Referring Anthem Blue Cross Covered Individuals to health care professionals and facilities that participate in the Anthem Blue Cross Prudent Buyer network.
2. Requesting pre-service review, when required, will avoid retrospective payment denial for lack of Medical Necessity for hospital services provided to Anthem Blue Cross Covered Individuals. The participating physician must request a review from Anthem Blue Cross UM prior to a scheduled admission or service by calling 800-274-7767.
3. Verifying Covered Individual benefits by contacting the Customer Service number on the back of the Covered Individual's ID card.
4. Components of Request for Pre-service Review. When pre-service review is required, the participating physician should be prepared to provide the following information to Anthem Blue Cross at the time of the request:
   a. Patient's name and Anthem Blue Cross ID number
   b. Diagnosis (ICD-9 code OR successor codes) (for Behavioral Health cases, also include AXIS 1-5 of DSM IV)
   c. Reason for admission
   d. Scheduled admission date
   e. Planned procedure or surgery [most specific *Current Procedural Terminology* (CPT) code]
   f. Planned procedure or surgery date
   g. Name and location of the participating hospital where the Covered Individual will be admitted or have the requested service provided
   h. Participating physician name and telephone number
   i. Clinical indications for the planned admission, procedure or service including, when appropriate, diagnostic test results
   j. Anticipated duration of services (e.g., planned length of stay or number and frequency of home health visits)
5. Components of requests for Care Coordination Behavioral Health reviews. You may access a copy of this form with the listed components by logging in to ProviderAccess®, at provider2.anthem.com/wps/portal/ebpmybcc

Electronic Data Exchange

Facilities will make best effort to support Anthem Blue Cross 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 Blue Cross server to report inpatient admissions. All records received for a specific day will be verified via a confirmation report, which is sent from Anthem Blue Cross 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

Out-of-network Referrals

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

When there are no Anthem Blue Cross Prudent Buyer network health care professionals (for specialty and/or ancillary care) available in the Covered Individual's service area, the Covered Individual or Provider may request an out-of-network referral by calling the UM department at 800-274-7767. Requests for out-of-network referrals must be made prior to services being rendered.

A UM clinical reviewer will review requests for out-of-network referrals. When an out-of-network referral is approved, the Covered Individual 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 Blue Cross website. This supports our efforts to provide greater transparency for Providers, Covered Individuals and the public in general.

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

For retro appeals only: To request an appeal of services that have been previously denied as not medically necessary or experimental/investigational, include either the Provider Dispute Resolution (PDR) form or a letter of appeal. If services were initially denied due to lack of clinical information or no UM

review, submit your request for retrospective review with the claim; no PDR form or letter of appeal should be attached. Specific instructions of how and where to file an appeal can be located on your adverse determination letter or Explanation of Benefits (EOB).

The *Covered Individual Grievances and Appeals Process* section of this Manual provides information regarding the process for addressing adverse determinations and appeals.

AIM Specialty Health (AIM®)

Since September 2008, AIM has administered Anthem Blue Cross' radiology benefits management program. Since November 2012, AIM has also administered Anthem's Sleep Study Program for home-based study and outpatient Facility-based sleep testing and therapy services. AIM is an affiliate of Anthem Blue Cross and is a nationally recognized leader in advanced imaging management, with programs covering more than 35 million Covered Individuals. 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. Ordering physicians must contact AIM to obtain a preauthorization for non-emergency home-based sleep studies and outpatient Facility-based sleep testing and therapy services.

Note: Imaging and Sleep Test/Study 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 Blue Cross' Provider portal, ProviderAccess® at anthem.com/ca > Providers. Once you have logged in to ProviderAccess, click the AIM's Radiology Management Program link. Then click 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 CPT 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 Blue Cross' Provider portal, ProviderAccess, at anthem.com/ca > Providers.

Online Sleep Study/Test requests: aimspecialtyhealth.com/gowebsleep

If you are not currently registered for Anthem Blue Cross' ProviderAccess, you will need to register online at anthem.com/ca > Providers. Please allow 24 hours for the processing of your registration.

Telephone Requests – Requests can be submitted to AIM via telephone. Providers can call AIM toll-free at 877-291-0360, Monday through Friday, 7 a.m. – 5 p.m. 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:

- Covered Individual ID 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 Covered Individual's health benefit plan.

Note: Retrospective requests will not be considered.

Clinical guidelines can be accessed on AIM's home page at aimspecialtyhealth.com or on the Anthem Blue Cross website at anthem.com/ca, select *Providers*, and then click on "Enter," under the "Provider Home" tab click on "Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements."

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, please 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 877-291-0360, Monday through Friday, 7 a.m. – 5 p.m. PST.
4. The rendering Facility can view authorizations online through Anthem Blue Cross' Provider portal, ProviderAccess, at anthem.com/ca > Providers. Select "Referrals & Pre-auths" and then click on "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.

Outpatient Cardiac Diagnostic Imaging Modalities

> **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**

Beginning with services provided on and after **August 3, 2009**, Anthem Blue Cross 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 Capture for Advanced Diagnostic Cardiac Imaging Services

Anthem Blue Cross 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 Blue Cross in their clinical review of cases.

AIM's Radiology Management and Sleep Programs and OptiNet® Survey Tool

Anthem Blue Cross is dedicated to helping meet the ever-changing needs of our customers and helping our Covered Individuals optimize the value of their health care dollars. To support consumers looking for tools to guide them in making informed health care decisions, Anthem Blue Cross has gathered information about the imaging capabilities of **all contracted Providers who perform certain advanced diagnostic imaging and sleep 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).

In December of 2008, Anthem incorporated average modality cost information into *OptiNet.* Cost values were determined based on the allowed amount of paid claims from the previous year for both professional and technical component claims. The average cost information for each advanced imaging modality grouper is presented. Both the information collected on the imaging capabilities of Anthem Providers, as well as the

average cost value for advanced imaging modality groupers, has been made available to Anthem physicians who request preauthorization for an advanced diagnostic imaging service via telephone or online.

When an ordering physician submits a preauthorization request online, a table highlighting the site scores and average modality 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.

Please note that any network imaging Provider may be selected to perform the requested imaging services. If the Covered Individual 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, please log on to ProviderAccess, click on 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 assessment, you will be able to access your survey information, site score, and cost information online and update your information as appropriate.

If you are not currently registered for Anthem Blue Cross' ProviderAccess, you will need to register online at anthem.com/ca > Providers. Please allow 24 hours for the processing of your registration request.

Denial Process

Anthem Blue Cross 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 Covered Individual's EOC or obtained by calling the toll-free Customer Service number on the Covered Individual's ID card.

Benefit levels and medical appropriateness review requirements differ significantly, depending on the Covered Individual'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 Covered Individual-specific benefit information and plan-specific information regarding medical management requirements.

Anthem Blue Cross Prescription Drug Pre-service Review Process

Prescription drugs may require pre-service review depending on drug and/or Covered Individual plan requirements. Providers must verify whether the requested drug requires pre-service review by contacting the Customer Service number on the back of the Covered Individual's ID card.

Specific to Fully Insured Covered Individuals

Under SB 866, the Department of Insurance and the Department of Managed Health Care developed a uniform prior authorization form (Prescription Drug Prior Authorization Request Form) and will implement SB 866 effective October 1, 2014 for fully insured Members regardless of the state where the Member resides, the state where the Provider is located, or the state where services are provided. For fully insured Members, upon implementation, the plan, or delegated medical group, must notify the prescribing Provider within two business days of receipt of a completed Prescription Drug Prior Authorization Request Form that:

A. The prescribing Provider's request is approved;
B. The prescribing Provider's request is disapproved as not medically necessary or not a covered benefit;
C. The prescribing Provider's request is disapproved as missing material information necessary to approve or disapprove the request;
D. The patient is no longer eligible for coverage; or
E. The request was not submitted on the required form, and must be resubmitted using the approved Request Form.

Prescription Drug Prior Authorization Forms can be found online from the Pre-Service Medical Review Request Forms web page or in the *Links* section of this Manual.

For non-Fully Insured Covered Individuals, please refer to Utilization Management Pre-service and Review Timeframes sections above.

Specialty Pharmacy Medical Management Department

The Specialty Pharmacy Medical Management Department reviews for the Medical Necessity of specialty injectable or infusible medications that are covered under the Covered Individual's medical benefit. This program is an effort to speed up payments to Providers and help monitor Covered Individuals' receipt and frequency of specialty drug doses.

A list of specialty pharmaceuticals can be obtained by visiting anthem.com/ca. To obtain a pre-service medical review for a specialty pharmaceutical, call our Utilization Review department at 866-580-5293, or physicians may fax in the Prescription Drug Prior Authorization Request Form to 866-408-7195.

Federal Employee Program (FEP) Guidelines

The Federal Employee Program's Managed Care Services (FEPMCS) are co-managed by Anthem Blue Cross and Blue Shield of California, two separate and distinct health plans.

Effective January 1, 2011, FEP no longer requires prior approval for outpatient care for mental health and substance abuse treatment.

Effective January 1, 2015, the FEP plan is encouraging Members to utilize Blue Distinction Centers for bariatric surgery, cardiac care, knee and hip replacement spine surgery, and complex/rare cancers.

The FEP plan requires precertification for all inpatient admissions, prior approval for BRCA related procedures, surgery for morbid obesity, surgical correction of congenital anomalies, surgical intervention to correct accidental injuries to jaws, cheeks, lips tongue roof/floor of mouth, IMRT, hospice, transplant and clinical trials.

No precertification is required for maternity admission for routine delivery unless patient stays more than 48 hours after vaginal delivery or 96 hours for cesarean section

Below is the Anthem Blue Cross and Blue Shield of California's FEP Responsibility Grid. Please contact the appropriate health plan for your service request.

1. Anthem Blue Cross FEP UM can be reached at 800-860-2156
2. Blue Shield of California FEP UM can be reached at 800-633-4581
3. Blue Shield of California FEP CM can be reached at 800-995-2800

FEP Responsibility Grid

FUNCTION	Blue Cross	Blue Shield
Utilization Management – Inpatient		
• Acute		X
• Behavioral Health – IP		X
• Acute Rehabilitation		X
• SNF/TCU (with Facility-based tax ID number)		X
• LTAC		X
Utilization Management – Outpatient		
• Home Health		X
• DME		X
• Professional Services		X
• Outpatient Surgery		X
• Behavioral Health		X
• Transplant Pre-service Reviews		X

FUNCTION	Blue Cross	Blue Shield
Claims Payment – Inpatient		
• Acute	X	
• Behavioral Health	X	
• Acute Rehabilitation	X	
• SNF (Freestanding Flexible Benefit)	X	
• TCU Unrelated Facility	X	
• Professional Fees (Hospital Based)	X	

FUNCTION	**Blue Cross	***Blue Shield
Claims Payment – Outpatient		
• Home Health	X	X
• DME	X	X
• Behavioral Health	X	X
• Professional Services	X	X
• Outpatient Surgery	X	X
• Ambulance – Ground and Air	X	X
• Ambulatory Surgery Center (ASC)	X	X

***Blue Cross – receives claim when Facility submits on UB-04*

****Blue Shield – receives claim when services are submitted on HCFA – CMS-1500*

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.*

Transition Assistance Program for PMG/IPA Closures or Terminations, Hospital Closures or Terminations, and Newly Covered Enrollees

The Transition Assistance Team will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Covered Individuals, 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 for a period of time, according to regulatory or accreditation requirements, necessary to complete a course of treatment and to arrange for a safe transfer to another Provider.

Covered Individuals 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 Covered Individuals 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. Covered Individuals can call the Customer Care number located on the back of their ID card or check our website to see if their current Provider is in our network.

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 877-214-1781. Covered Individuals 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.

Following receipt of an application, Covered Individuals will receive a telephonic acknowledgement from the Transition Assistance Team. The Team will work with the Covered Individual and Provider to determine eligibility and care needs. A determination will be made within two (2) business days from the receipt of all

information necessary to make a determination. The Covered Individual 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 or medical director for review. In addition to clinical denials, cases are referred to the PCR or medical director 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 Blue Cross' in-network rate, no COC/TOC would be offered. Covered Individuals 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, the Transition Assistance Team will work with the treating Provider as needed to develop the plan of care. Covered Individuals are covered at the in-network benefit level until treatment is concluded or until the Covered Individual can be safely transitioned to an Anthem Blue Cross Network Provider. This will vary on a case-by-case basis.

Covered Individuals 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.

Covered Individuals being treated for non-acute or chronic clinical conditions are usually not eligible for coverage of treatment by non-Network Providers. If the Covered Individual 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 Covered Individual should select an in-Network Provider to meet their ongoing health care needs and they do not need to request COC/TOC. If the Covered Individual needs assistance selecting a new Provider, they should contact Anthem Blue Cross Customer Care.

Covered Individuals who have elected to use an out-of-Network Provider through their PPO benefit or "opt-out" (Point-of-Service) plan, will not be eligible for transition assistance and they should contact Customer Care to identify an in-Network Provider or they may continue using their out-of-network benefit. Covered Individuals who choose to continue care with a physician 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.)

Comprehensive Case Management

Overview

The foundations of Anthem's Case Management (CM) program include a focus on addressing gaps in care, care transition issues, Member's self-management plan of care, and effective communication with the physician and Member's support system. To achieve this objective, the case managers work in partnership with integrated teams that include the Covered Individual, their caregivers as appropriate, physicians, CM

medical directors, pharmacists, behavioral health case managers and others to support a Covered Individual-centric plan of care.

Identification of Cases

Anthem CM introduced a Readmission Predictive Modeling (RPM) process to our case identification processes. This RPM methodology identifies and assigns a risk score to every Covered Individual admitted to an inpatient acute care Facility, when Anthem is notified. The risk score is calculated using various data elements specific to the Covered Individual, but include inpatient and outpatient utilization history, pharmacy data, claims data and Covered Individual demographics. Covered Individuals who meet the established Risk Score criteria are referred to CM for outreach and engagement.

There are other methods by which cases are identified CM, in addition to the RPM process. These include referrals from various sources (physicians, health care Providers, inter-departmental, employer group referrals) as well as Covered Individual/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 Covered Individual 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 surgery candidates
- Oncology, Hospice/End of Life care
- Organ or stem cell/bone marrow transplants
- ELIZA, IVR supported technology, referrals including:
    - Preadmission with 5 day prior notification
    - Post discharge
    - High dollar claimant
    - Post-Case Management graduation

Program Enrollment and Covered Individual Engagement

Once a Covered Individual has been identified for potential CM, the Covered Individual is contacted for program enrollment. With Covered Individual acceptance of CM, a RN case manager performs an assessment of needs to identify gaps in care and care transition issues. 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 Covered Individual, the family, involved health care service Providers, and the treating physician to collaboratively develop a Covered Individual-centric care plan, establish goals and implement interventions designed to meet Covered Individual goals. The initial and subsequent communication ensures that the Covered Individual understands their self-management plan of care,

his/her significant others are involved in the Covered Individual's care and they are empowered to make decisions regarding CM plans. This communication supports a more complete and thorough assessment of the Covered Individual's needs and ensures that Covered Individual 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 Covered Individual declines participation, the case manager may work with the health care treatment team to monitor progress through the health care continuum.

Case managers serve as Covered Individual advocates and facilitate high-quality, cost-effective treatment plans and access whenever necessary. Case managers help identify quality Providers and vendors in the Covered Individual's area and are integral in helping coordinate the Covered Individual's care with multiple Providers. In addition, case managers, in collaboration with the treating physician, help identify gaps in care and transition Covered Individuals 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 at any time to provide guidance on the management of a particular case or to facilitate communication with treating physicians or other Covered Individuals of the health care team.

Cases are closed when goals are met, if the Covered Individual becomes ineligible for benefits, or the Covered Individual declines further participation in the CM program.

A Covered Individual may self-refer or a Provider may refer a Covered Individual to Anthem's Case Management team by calling 888-613-1130. To refer a Medicare Advantage PPO Covered Individual, please call 866-797-9884.

Integration Health Services

All of our medical management programs including CM, UM, 360° Health® disease management/condition management programs and behavioral health programs, are well integrated, ensuring each Covered Individual receives the attention and information he or she needs, while also maintaining a continuum of care (availability of programs depends on the Covered Individual's benefit plan).

Our CM and *360° Health* disease management/condition management programs are integrated, allowing for early identification and evaluation of chronic health issues through referrals into and from each program. A real-time, online medical management computer system helps to further connect our programs. All CM and disease management/condition management activities are organized through the system. The system also enables us to record customized features for our clients and groups.

As part of our *360° Health* program, nurses from our 24/7 NurseLine may also refer Covered Individuals into CM or one of our disease management/condition management programs. Likewise, our case managers may refer Covered Individuals to our NurseLine.

Centers of Medical Excellence Program

The Anthem Blue Cross Centers of Medical Excellence (CME) program for certifying transplant Facilities ensures Covered Individuals that all transplant centers meet strict clinical criteria and maintain high levels of service. Refer to the *Anthem Centers of Medical Excellence Manual* in the *Exhibits* section of this Manual.

Anthem Blue Cross' 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 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 as outlined in the *Anthem Centers of Medical Excellence 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.

Transplant Life Transitions Program

Transplant Life Transitions Case Management (CM) is comprised of specially trained nurses. These case managers specialize in the management of Covered Individuals 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 Manual* located in the *Exhibits* section of this Manual.

Pre-certification and Admission Process for Transplants

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 Covered Individual's ID 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 Covered Individual 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 Covered Individual's recertification, a representative from the CME/Facility or the Covered Individual's physician calls the Anthem
Blue Cross Transplant Life Transitions Department at 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 Covered Individual's eligibility. The Transplant Life Transitions 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 Covered Individual.

When admission for transplant occurs, the CME/Facility contacts the assigned transplant case manager for ongoing CM.

Review Process

Recertification. For Covered Individuals 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.

Care Coordination Review. Determines whether a continued inpatient stay is medically necessary. Such review is required for all Covered Individuals not discharged within the approved length of stay.

Retrospective Review. When precertification has not been performed and the transplant evaluation or procedure has been performed, a thorough review will be done by the Anthem Blue Cross Center for Clinical Evaluation and Teaching (CCET) department to determine if services were medically necessary.

On-site Review. Anthem Blue Cross may have the ability to conduct on-site utilization review and CM, including chart review, concurrently or retrospectively, as required at the time of admission or during the course of hospitalization. The on-site reviewer will be permitted to discuss the Covered Individual's treatment plan with the hospital health care professionals involved in the Covered Individual's care. On-site reviews are performed on a mutually agreed-on schedule between Anthem Blue Cross and the CME/Facility.

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 Covered Individual are contacted both verbally and in writing. Peer-to-peer consultations are offered to the treating physician by the medical director. Based on the Covered Individual'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 Covered Individual
2. Specialty care
3. Providing assistance for network development

You can contact Transplant Life Transitions Program at:

Anthem Blue Cross
Transplant Life Transitions Program
13550 Triton Park Blvd
Mail Point: OH0102-C639
Louisville, KY 40223

Telephone number: 888-574-7215
Fax number: 877-264-4540

Additional Requirements

Audits/Records Requests

On occasion, Anthem Blue Cross 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 Blue Cross in the event there is a quality of care incident that involves a Covered Individual.

Utilization Statistics Information

On occasion, Anthem Blue Cross may request utilization statistics for disease management purposes using coded services identifiers. These may include, but are not limited to:

- Covered Individual name
- Covered Individual ID number
- Date of service or date specimen collected
- Physician name and/or ID number
- Value of test requested or any other pertinent information Anthem Blue Cross deems necessary

This information will be provided by Facility to Anthem Blue Cross at no charge to Anthem Blue Cross.

Failure to Comply With Utilization Management Program

Facility acknowledges that the Plan may apply monetary penalties as a result of Facility's failure to provide notice of admission or obtain pre-service review on specified outpatient procedures, as required under this Agreement or for Facility's failure to fully comply with, and participate in, any cost management procedures and/or UM programs.

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Introduction

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

The Anthem Blue Cross Grievances and Appeals (G&A) Department administers the formal grievances and appeals process. G&A is responsible for ensuring a consistent procedure for documenting, investigating, resolving, and responding to Covered Individual issues in a timely and accurate manner.

The Anthem Blue Cross Behavioral Health (BH) G&A Department is responsible for addressing Covered Individual grievances and appeals related to behavioral health care services and treatment. The term "G&A" used throughout this section refers to both Medical G&A and BH G&A, unless otherwise specified.

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

Covered Individual Representation

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

A signed designation of representative form (DOR) is not required when the Covered Individual's practitioner, acting on behalf of the Covered Individual, submits a pre-service or concurrent appeal. If a Covered Individual is a minor, or is incompetent or incapacitated, then the parent, guardian, conservator, relative or other designee of the Covered Individual, 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 "Covered Individual" will refer to the Covered Individual, designated representative or health care Provider/Facility acting on behalf of the Covered Individual. G&A follows HIPAA privacy standards to ensure Covered Individual, medical record and data confidentiality.

Right to Submit Additional Information During Appeals Process

Covered Individuals 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 Covered Individual, the health care Provider and the Facility rendering care, upon request.

Grievances and Appeals Resolution Timeframes

- G&A must resolve standard (non-urgent) Covered Individual grievances and appeals within 30 calendar days from the Anthem Blue Cross receipt date. G&A will consider the Covered Individual'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 Blue Cross 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 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).

Covered Individuals With Linguistic and Cultural Needs, Limited English Proficiency, and Other Communicative Impairments or Disabilities

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

Background Information

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

Medicare Advantage and Medicare Supplement business in California. Under applicable law and regulations, the DMHC requires that every managed care health plan establish and maintain a grievance system through which Covered Individuals 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 Covered Individual or the Covered Individual's representative. 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 Blue Cross.

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 Covered Individual's benefit plan.

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.

G&A Staff and Scope of Responsibility G&A is comprised of a team of board-certified physicians (medical directors), nurses, behavioral health clinicians, and G&A analysts and Behavioral Health (BH) coordinators trained in the G&A process. The G&A team is charged with resolving Covered Individual grievances and appeals through an equitable, timely and consistent process, and communicating resolutions in a clear, concise manner.

The Anthem Blue Cross Grievances and Appeals Officer has primary responsibility for the Anthem Blue Cross grievances and appeals process and monitors the operation of the system on a continuous basis to identify any emergent patterns of grievances/appeals. This individual is also responsible for ensuring compliance with reporting requirements.

The Grievances and Appeals Medical Directors 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. The medical director or his designee making the final decision on an appeal is an individual who did not participate in any prior review and is not a subordinate of any previous reviewer and will not have participated in the initial denial. All appeals involving Medical Necessity and investigational treatment are reviewed by a peer clinical reviewer (PCR) in the same or similar specialty as the area of care under review.

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.

Grievances and Appeals Clinical Staff includes licensed nurses and licensed behavioral health clinicians, who coordinate the review and investigation of clinical grievances.

Grievances and Appeals Analysts are non-clinical staff responsible for the review and resolution of administrative aspects of grievances and appeals.

Grievances and Appeals Clinical Associates, Behavioral Health Clinicians and an Audit Team handle special projects and tasks including, but not limited to, the following:

- Investigating and responding to Covered Individual regulatory complaints, and regulators' request for information/records to facilitate the Independent Medical Review (IMR) process
- Training and mentoring G&A associates on all aspects of the grievance and appeals process, including changes in regulatory and accreditation standards as applicable, and correct usage of the G&A database documentation system
- Ensuring that G&A policies and procedures are compliant with regulatory and accreditation standards, and educating staff of any policy changes that affect the processing of grievances/appeals
- Internal audits of G&A cases to ensure compliance
- Coordination of review of cases referred to the Anthem Blue Cross Peer Review or Credentialing Committees and recording minutes of the meetings
- Trend analysis of grievances and reporting results to the designated medical director

Commercial Plans

Initial Determination Process and Denial Notification Procedures

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

Process for Submitting Covered Individual Grievances and Appeals to Anthem

Covered Individuals may request a grievance or appeal regarding any denial of authorization resulting from a request for a prospective, concurrent or retrospective review of health care service. Covered Individual grievances and appeals may be submitted in writing or verbally. Covered Individuals and their representatives also have the option of submitting grievances/appeals online to Anthem Blue Cross via the Internet. The grievance website is accessed at anthem.com/ca. 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 Covered Individual may also print the form, complete it, and send it to Anthem Blue Cross at the address below.

Grievances or appeals received verbally by the Customer Service Unit are documented on the Customer Service Inquiry Tracking System and routed to the G&A unit for investigation and resolution. Grievances or

appeals received verbally by the Utilization Management (UM) Department are documented in a clinical documentation system and routed to the appropriate G&A unit.

The Covered Individual or Covered Individual's representative should document the circumstances surrounding the grievance/appeal and submit this information along with any available medical documents, including medical records or claims to Anthem Blue Cross. Covered Individuals may refer to their EOC or contact Anthem Blue Cross Customer Service for further information on the G&A process. Covered Individuals may submit a grievance and/or appeal in writing to G&A at the following address:

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

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

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

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

Anthem Blue Cross
Medicare Complaints Grievances and Appeals Department
4361 Irwin Simpson Rd – OH0102-C535
Mason, OH 45040

Acknowledgement and Investigation of Appeals

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

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 Covered Individual 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 Blue Cross will obtain the necessary medical information used in the initial denial, as well as additional medical information from the Provider, as appropriate. When a request for information is sent, the Provider is required to respond within seven to 10 calendar days of the request, or sooner depending on the clinical urgency of the case.

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

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

After Anthem Blue Cross has completed its review, a written statement of its resolution is sent to the Covered Individual 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 Covered Individual's EOC, including the right to request an independent medical review (IMR), as applicable.

Covered Individuals 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 Covered Individual for this information. Covered Individuals may request this information by calling G&A at 800-365-0609 or the TDD line at 866-333-4823 for the speech and hearing impaired.

A written request for information should be mailed to:

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

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

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

Expedited Appeals

Covered Individuals or their representatives have the right to request an expedited appeal. Expedited appeals are cases involving an imminent and serious threat to the health of the Covered Individual 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 Covered Individuals who remain inpatient in a Facility after receiving emergency care.

When a grievance or appeal meets expedited criteria, Anthem Blue Cross must immediately notify the Covered Individual of his or her right to request assistance from the DMHC, as applicable to the Covered Individual's plan, and provide the Covered Individual with the DMHC's toll-free number and TDD line. Covered Individuals are not required to participate in Anthem Blue Cross' expedited grievance or appeal process, prior to contacting the DMHC for assistance.

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

and, if denied, a description of further dispute resolution options, which may include the right to request an IMR.

If the appeal request does not meet the criteria for an expedited review, the Covered Individual and Provider/practitioner 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
To speak with the Behavioral Health Medical Director, call 858-571-8129

Emergency Care and Services

Emergency care is covered, in accordance with the terms and benefits of the Covered Individual'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 care is 30 calendar days from receipt of the appeal by Anthem Blue Cross.

In accordance with *California Health and Safety Code, Section 1368.02(b)*, a Covered Individual's grievance rights in California include the right to request an IMR for payment disputes regarding the denial of emergency or urgent medical services.

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 Covered Individual, unless:

1. The Plan reasonably determines that emergency services were not rendered, or
2. The Covered Individual did not require emergency services, and the Covered Individual 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 Covered Individuals and health care Providers to obtain timely authorization for medically necessary care. This includes follow-up care after a Covered Individual's emergency condition has been stabilized, but the treating physician believes the Covered Individual 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 Covered Individual

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 California 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).

Covered Individuals who seek care out-of-area must submit their bills directly to Anthem Blue Cross for reimbursement. The claims are reviewed retrospectively to determine if the condition meets the criteria for emergency or urgently needed services as defined in the Health and Safety Code. If denied, Covered Individuals have the right to request an IMR from the appropriate regulator (e.g., DMHC or CDI), as applicable.

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 Covered Individual'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 Covered Individual or unborn child
5. The specific situation is also defined as an emergency if the Covered Individual ("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 Covered Individual, resulting from an unforeseen illness, injury or complication of an existing condition for which treatment cannot be delayed until the Covered Individual returns to the Plan's service area.

Urgently needed services also include maternity services necessary to prevent serious deterioration of the health of the Covered Individual or the Covered Individual's fetus, based on the Covered Individual's reasonable belief that she has a pregnancy-related condition for which treatment cannot be delayed until the Covered Individual returns 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 (California AB 55 Health and Safety Code, Section 1370.4)

If a request for investigational treatment is denied, UM will notify the Covered Individual and Covered Individual's practitioner in writing of the basis for the denial and will provide the applicable criteria used to make the decision. In addition, the Covered Individual is informed of further appeal rights, including the right to IMR.

Additional Dispute Resolution Mechanisms Available to Covered Individuals

If the Covered Individual continues to be dissatisfied with the resolution of his/her appeal, or if the appeal has not been resolved by Anthem Blue Cross after at least 30 days, the Covered Individual may submit the appeal to the appropriate regulator, (e.g., DMHC or the CDI), as applicable. If the Covered Individual's case involves an imminent threat to his/her health, as described above, the Covered Individual is not required to complete the Anthem Blue Cross grievances/appeals process or wait at least 30 days, but may immediately submit their appeal to the DMHC/CDI.

When a Covered Individual submits an appeal to the DMHC, the plan has five days to reply therefore a rapid response from Providers is critical. If the prior decision has been reversed and the issues have been resolved, the plan is still required to provide a written confirmation of the resolution, including an explanation of the reversal. If the Plan upholds the decision, they are required to provide all written correspondence, including letters and emails between the Plan, Provider or Covered Individual, telephone logs or other documentation of telephonic communication, any Plan medical policies, clinical criteria or

coverage policies relating to the dispute, any outside clinical or coverage review, internal notes reflecting the handling of the Covered Individual's dispute, and any reference to support the decision.

Note: Not all PPO Plans are under the jurisdiction of the DMHC or the CDI. A Covered Individual may be an employee of a state, federal or administrative services only (ASO) group. If this is the case, Anthem Blue Cross will advise the Covered Individual to refer to his or her EOC for information regarding further dispute resolution options or the Covered Individual may call customer service at the number on the Covered Individual's health plan ID card for assistance.

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*, an enrolled Covered Individual may request an IMR through the DMHC or CDI (as applicable) for Anthem Blue Cross denials regarding:

1. Services that are denied, delayed or modified by Anthem Blue Cross based on medical judgment 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 Covered Individual usually must participate and complete the Anthem Blue Cross 30-day grievance/appeal process before applying for an IMR, except in those cases where the DMHC determines the case should be expedited. Covered Individuals 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 Blue Cross denial letter. The Covered Individual may apply for an IMR within six months of the denial. The Covered Individual will pay no application or processing fee of any kind.

The application for IMR will be received and processed directly by the DMHC/CDI. The DMHC/CDI 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 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 IMR organization is binding on Anthem Blue Cross.

At the conclusion of the Covered Individual's appeal review by the DMHC/CDI, or prior to and instead of review of the Covered Individual's case by the DMHC/CDI, the Covered Individual has the right to seek legal redress through binding arbitration, if contractually applicable.

Releasing Information to Covered Individuals

Anthem Blue Cross is committed to maintaining the highest level of confidentiality for its Covered Individuals' medical records. To protect Covered Individuals' privacy and standardize the information release process, Covered Individuals' requests for release of information is handled using the following procedure:

1. Direct all Covered Individuals requesting release of medical information, or those who have questions concerning medical information, to call Anthem Blue Cross' Customer Service Department.
2. Only questions involving claim payments verification are answered over the telephone. No other information is given out, including answers on claim type or other claims-related issues. A Covered Individual requesting any other information is sent an *Individual Authorization for Release of Protected Health Information (PHI) form.*
3. The request must be filled out by the person whose medical information is being requested. A person is not able to obtain information for a spouse, parent or independent adult child. In accordance with California law, the designated age at which parents no longer have access to their child's records is 18 years of age.

   In accordance with California law, HIV/AIDS information is released only when a notarized request is received from the Covered Individual.
4. In accordance with the above procedure, information requested is sent out within 10 days of receipt of the *Individual Authorization for Release of PHI form*. The Customer Service Department keeps all requests in the Covered Individual's file, and documents the date and nature of the information being released.

   The Customer Service representative checks the signature on all *Individual Authorization for Release of PHI forms* against the Covered Individual's signature on file, and the Customer Service manager or supervisor then signs off on each request. This acts as a double-check system to prevent releasing any confidential information to the wrong party, and prevents forgery.
5. Any *Individual Authorization for Release of PHI forms* that are filled out incorrectly will be returned to the Covered Individual, with an explanation of why his or her request cannot be fulfilled and instructions for filling out the form correctly.

Confidentiality of Medical Information

As a participating Provider, confidentiality is critical to both Covered Individuals and families undergoing assessment and treatment for behavioral health conditions. Anthem Blue Cross 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 Blue Cross Providers. Anthem Blue Cross requires that participating Providers adhere to these same standards.

Records maintained as part of the Covered Individual grievance and appeal resolution process are considered confidential and are maintained in compliance with legal requirements. These documents include Covered Individual grievances and appeals, practitioner and Provider responses, medical records, committee review documents, consultant reviews, and committee minutes.

To make a determination regarding a Covered Individual 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 Covered Individual is notified. Thus, as required by law, Anthem Blue Cross will notify the Covered Individual 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 Covered Individuals

Anthem Blue Cross HMO/POS/PPO Grievance Process

Review of quality-of-care and service issues

The Anthem Blue Cross HMO/POS/PPO Grievance Process is for the review of quality-of-care/service complaints from Covered Individuals or their representatives. Grievances and Appeals (G&A) is responsible for the review, resolution and response to Covered Individual quality-of-care and service grievances. Issues that relate to quality of care in all treatment settings, including hospitals, are reviewed through Anthem Blue Cross' Quality Assurance/Peer-Review Process. By law, the information related to quality assurance and peer-review issues is confidential and protected under *California Evidence Code, Section 1157*, and the *California Health and Safety Code, Section 1370*. Disclosure of the results of a quality-of-care review to Covered Individuals or third parties is not permitted. Covered Individuals are sent an acknowledgement letter within five calendar days of Anthem Blue Cross receiving the grievance.

Medical records and Provider responses that will assist with the review of cases are requested in writing and may be submitted by mail, fax, or as electronic documents. The Provider is asked for a specific response to the grievance within seven to 10 calendar days (dependent on Provider Agreements) of the request. The department and medical directors will collaborate with National Provider Solutions to receive a response from non-responders without disclosing confidential information.

A Provider response is a formal written response to the Covered Individual's grievance. The response must address all pertinent issues identified in the grievance. The Provider should provide the supporting documentation or medical records used in the determination.

California law specifically stipulates that quality-of-care and service grievances must be resolved within 30 calendar days and a written resolution sent to the Covered Individual. If the Provider must conduct a more thorough analysis of the quality issue and the requested timeframe is insufficient, we ask that the Provider send preliminary findings or notify G&A that a more thorough review of the issue is under investigation. In addition, G&A should be informed if there are extenuating circumstances that prevent you from complying with our request within the stated timeframe.

If the requested information is not received, a medical director, physician advisor, or the Behavioral Health Peer-Review Committee may make a decision based upon the information available; the Provider's lack of response and cooperation in the peer-review process will be noted in their credentialing file. Providers will receive a closure letter upon completion of the review providing feedback regarding the outcome of the investigation.

Grievances and Appeals will send a written resolution letter to the Covered Individual within 30 calendar days (or sooner, depending on clinical urgency) that addresses all unresolved issues, and will provide an explanation of further appeal rights, when appropriate. For quality-of-care issues, the letter will provide an explanation of the confidential nature of the quality assurance or peer-review process, and emphasize that the details and outcome of a quality-of-care review cannot be disclosed.

Tracking and Trending

All practitioners identified in grievances are evaluated for a history of previous severity levels assigned during the past 12 months prior to the current issue. The Anthem Blue Cross medical director or his designee is notified of any practitioners who have a trend in quality issues. Refer to Exhibit – Anthem Blue Cross *Severity Levels for Quality Assurance*. An analysis of the previous cases is performed to determine if there is a common theme among the issues and whether a corrective action plan or other measures are indicated.

Upon completion of a quality-of-care review, the Provider's name and assigned severity level are entered into the G&A database for tracking and trending purposes. If the case is forwarded to the Anthem Blue Cross Peer-Review Subcommittee, the committee will assign the severity level to the involved Provider, and the information is entered into the database.

Cases presented to the Anthem Blue Cross Peer Review Subcommittee or the BH Peer Review Subcommittee will contain all relevant available medical information, a copy of our peer clinical reviewer's assessment, and a written response to the issue(s) from the involved practitioner. The applicable committee will conduct a thorough review of the case and is responsible for the final determination and assignment of a severity level. The committee may formulate recommendations to the Provider to address confirmed quality-of-care issues or trends that have been identified.

The outcome of the committee review is included in the physician's credentialing file as part of the recredentialing process. However, the Peer Review Subcommittee may recommend that the credentialing committee take immediate corrective action against a physician based on the outcome of the peer review prior to the physician's recredentialing due date. When a significant quality-of-care issue or a sentinel event is identified, the case is forwarded to the credentialing committee for further review and action, as appropriate.

Corrective Action Plans

For certain quality-of-care or service issues, the G&A medical director or his designee may request that the Provider create a corrective action plan (CAP). The purpose of a CAP is to ensure that when problems are identified, corrective measures are taken to address the issue and to prevent or minimize the possibility of a reoccurrence in the future. The ultimate goal is to improve the quality-of-care and service provided to Covered Individuals.

Grievance Data Used in Provider Credentialing

Physicians identified in quality-of-care grievances are assigned severity levels with corresponding points indicative of the significance of the issue. Refer to Anthem Blue Cross *Severity Levels for Quality Assurance* located in the *Exhibits* section of this Manual. The Provider and severity level are tracked on the Anthem Blue Cross G&A database. Accumulated data is provided to the Anthem Blue Cross Credentialing

Department by report on a regular basis to assist with early detection of Provider quality issues between credentialing cycles.

Grievances and Appeals Reporting

G&A management reports G&A rates, categories and trends to the health plan's West Region Quality Committee (WRQC) on a quarterly basis. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee.

Description of Covered Individuals' Right to Independent Medical Review (IMR) for Investigational Treatment Denials

In accordance with *California Health and Safety Code, Section 1374.30* a Covered Individual may apply for an IMR after the plan has denied a request for investigational therapy for a life-threatening or seriously debilitating disease. Covered Individuals 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 Covered Individual's plan.

The IMR process outlined as follows examines the health plan's decisions regarding investigational therapies for Covered Individuals meeting all of the following criteria:

1. The Covered Individual 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 Covered Individual's physician certifies that the Covered Individual has a life-threatening or seriously debilitating condition, as defined above; for which standard therapies have not been effective in improving the Covered Individual's condition; for which standard therapies would not be medically appropriate for the Covered Individual; or for which there is no more beneficial standard therapy covered by the Plan than the therapy proposed.
3. Either (a) the Covered Individual'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 Covered Individual than any available standard therapies; or (b) the Covered Individual, or the Covered Individual'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 Covered Individual'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 Covered Individual than any available standard therapy; and the Covered Individual has been denied coverage by the Plan for a drug, device, procedure or other therapy recommended by the Covered Individual'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 Covered Individual wishes to proceed with an IMR, he or she should complete and sign the following forms from the applicable agency (Anthem Blue Cross includes the IMR application/instructions and pre-addressed envelope to the DMHC or CDI in denial letters to Covered Individuals):

Department of Managed Health Care (DMHC)*

- *IMR Application*
- *IMR Application Instructions*
- *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 Declaration of Relationship*
- *Pre-addressed Envelope to the CDI*

*Note: To obtain the most up-to-date forms, Covered Individuals may contact Anthem Blue Cross Customer Service at the telephone number on the back of their ID card.

The IMR application form should then be forwarded by the Covered Individual to the DMHC or the CDI. The Covered Individual's physician should complete the Physician Certification form. The Covered Individual 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 Covered Individual'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 Covered Individual's illness is considered terminal, the Covered Individual or the Covered Individual's representative or practitioner also has the right to request a conference with Anthem Blue Cross 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 Grievances and Appeals (G&A) Department at 800-365-0609, at the TDD Line 866-333-4823 or by sending a written request to the following address:

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

The Covered Individual may request a conference by completing the Covered Individual grievance form. Upon receiving the request, Anthem Blue Cross will provide the Covered Individual (if eligible), within 30 calendar days, an opportunity to attend a conference and to review the information contained in the denial. The conference will be conducted by an Anthem Blue Cross medical director or his/her designee who has authority to determine the disposition of the complaint.

Aside from the Covered Individual's attendance, the Covered Individual may designate a representative to attend with the Covered Individual or in his or her place. If the patient is a minor or incompetent, the parent, guardian or conservator of the Covered Individual, 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 Covered Individual or Covered Individual's physician needs additional information, they should call Anthem Blue Cross G&A Department at 800-365-0609 and ask to speak to a department manager.

California Department of Insurance

Covered Individuals can contact the CDI at 800-927-HELP (4357) or by fax at 213-897-5891.

Department of Managed Health Care (DMHC) Required Notification to Covered Individuals Regarding Grievances and Appeals Management Process

Note: The following information is provided to help you assist Covered Individuals in understanding the G&A process, and can be found in their EOC. Following is the notification given to Covered Individuals regarding the G&A management process:

If you have a question or concern, call the toll-free Customer Service number on your ID card, or write to Anthem Blue Cross.

If you are not satisfied with the first option, 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 Blue Cross 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 Blue Cross does not respond within 30 calendar 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 Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at 800-365-0609 or at our TDD line 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 888-HMO-2219 and a TDD line 877-688-9891 for the hearing and speech impaired. The department's website www.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 Covered Individual's plan is governed by Employee Retirement Income Security Act, 29 U.S.C. 1001, et. seq. (ERISA) *Section 502 (a)(I)(B)*, the Covered Individual 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 Covered Individual disagrees with the outcome of 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.

Member (Patient) Responsibility Agreement

The participating Provider may not bill the Covered Individual for care or services denied for payment on the basis of Medical Necessity, unless the Covered Individual 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 for days of acute care beyond those approved as medically necessary. See the *Covered Individual (Patient) Responsibility Agreement* in the *Exhibits* section of this Manual.

Prompt notification of an Anthem Blue Cross Covered Individual's admission, proactive discharge planning and effective communication between the Provider, Anthem Blue Cross and clinical staff ensure that medically inappropriate days are avoided, and minimize the financial liability risk for denied days.

Anthem Blue Cross Medicare Covered Individual Complaints

Anthem Blue Cross is a Medicare Advantage managed health care plan. CMS is the federal regulator for Medicare's managed health care plans, known as "Medicare Advantage plans" (MA). Under applicable law and regulation, the CMS requires that every health plan (Plan) establish and maintain a Grievances and Appeals (G&A) system, under which Covered Individuals may submit disputes regarding the authorization and payment of services, as well as issues relative to involuntary disenrollment from the Plan. Anthem Blue Cross procedures are designed to handle Covered Individual issues expeditiously and equitably. Anthem Blue Cross Covered Individual issues are divided into two types: Covered Individual grievances/complaints and appeals/reconsiderations. Quality grievances and appeals are administered by the Anthem Blue Cross

G&A Department. Covered Individual issues are resolved through one of two ways, depending on the type of issue, as defined below:

1. Grievance procedures apply when a Covered Individual complains about quality-of-service, quality-of-care or involuntary disenrollment and billing issues. The grievance process is not used to appeal service or claim denials.
2. Appeal/reconsideration procedures apply when a Covered Individual disagrees with a decision about payment for, or provision of, services. The request for appeal/reconsideration can pertain to an initial request for service denial or a claim denial.

It is possible to have Covered Individual issues that apply both to grievances and appeals. The procedures for grievances and appeals are mutually exclusive. If a Covered Individual addresses a grievance and an appeal at the same time, each issue is processed separately and simultaneously under the proper procedure.

The appeal process pertains to disputes involving an initial claim payment denial or a provision of services denial. The appeal must be submitted in writing by the Covered Individual, or by a representative appointed by the Covered Individual, within 60 calendar days from the date of the notice of the initial determination/denial. An exception to the 60-day timeframe may be made for good cause. Any appeal request submitted more than one year from the date of the initial denial letter will not be accepted for review. A letter is sent to the Covered Individual advising him or her of the rejection of the appeal request for review, and advising him or her of the grievance process.

All other complaint issues are handled through the Anthem Blue Cross Medicare grievance process including Covered Individual complaints regarding the quality of care/quality of service provided by the Provider and disputes of involuntary disenrollment and billing issues. The Covered Individual may request a review by completing a *Grievance Form* or asking the Anthem Blue Cross Medicare Member Services Department to complete the form.

Grievances related to quality and enrollment and billing issues are forwarded by the Anthem Blue Cross Medicare Member Services Department directly to G&A for review. The grievance review process is as follows:

1. An acknowledgment letter is sent to the Covered Individual within five business days of Anthem Blue Cross' receipt of the grievance.
2. The documentation submitted is reviewed by a dedicated Medicare Advantage G&A staff member. If additional information is required, a letter is sent to the Provider requesting medical records and/or the Provider's response to the Covered Individual's issue.
3. If the requested information is not received within the timeframe indicated, the G&A staff reviews the case based on the information available.
4. A letter is sent to the Covered Individual and the Provider at the review's conclusion, within 30 calendar days of receipt of the request.
5. All quality-of-care cases are reviewed by the G&A clinical staff, registered nurses and Anthem Blue Cross medical directors. If the Covered Individual is not satisfied with Anthem Blue Cross's written response to a quality of care complaint, the Covered Individual may take the issue to the Quality Improvement Organization (QIO) contracted with CMS for the State of California, Health Service Advisory Group (HSAG).

6. All grievances regarding a specific physician are reported monthly to the Credentialing Department. This information is included in the physician's credentialing file as part of the recredentialing process.

Medicare Medical Appeals Only

Medicare's term for appeal is known as "reconsideration." A Covered Individual may use the reconsideration process for any adverse organization determination (denial) rendered by Anthem Blue Cross that pertains to the following:

1. Any claims denied, in full or partially, by Anthem Blue Cross
2. Services furnished by non-contracting health care professionals or suppliers that the Covered Individual believes are covered under the *Anthem Blue Cross Agreement*, and should have been furnished by, arranged for or reimbursed by Anthem Blue Cross
3. Services that Anthem Blue Cross refuses to provide and the Covered Individual believes should be furnished
4. Any discontinuation or reduction of services

Reconsideration requests for service provision (Pre-service) are resolved within 30 calendar days (plus a 14 calendar days extension, if indicated), expedited requests within 72 hours (plus a 14 calendar days extension, if indicated), and claims payments or Post-service appeal are resolved within 60 calendar days; no extension is permitted for Post-service/claims related appeals.

<u>Appeal Review Timeframes:</u>

1. Expedited = 72 hours (+ 14 calendar days extension, if indicated)
2. Pre-service (Standard) = 30 calendar days (+14 calendar days extension, if indicated)
3. Post-service/Claims (Standard) = 60 calendar days (no extension allowed)

If, on appeal, the Covered Individual does not receive a fully favorable determination, the appeal is automatically forwarded to the CMS-contracted independent review entity (IRE) for review.

If the CMS contractor upholds the Anthem Blue Cross denial determination and the remaining amount in controversy meets the appropriate threshold, the Covered Individual has a right to request a hearing with an administrative law judge (ALJ). The threshold requirement is determined by the ALJ.

If the Covered Individual is dissatisfied with the ALJ's decision, he/she may further request a Departmental Appeals Board (DAB or The Board) review. The Board's determination is final and binding to the Covered Individual, unless he/she requests to appeal further.

The fifth and final appeal level involves the Federal District Court (FDC), aka Judicial Review. The right to judicial review in the FDC may be requested by the Covered Individual if The Board's decision is unfavorable and the amount remaining in controversy is $1,180 or more.

The reconsideration determination by the independent review entity is final and binding on Anthem Blue Cross. The binding arbitration clause in the Covered Individual's *Enrollment* form does not apply to disputes subject to the CMS appeals process.

How Medicare Advantage Enrollees Must Be Notified of Non-coverage of Inpatient Hospital Care

CMS has a rule titled "CMS Final Rule 4105-F" whereby *hospitals are required to deliver a revised version of the Important Message from Medicare, to inform Medicare beneficiaries, who are discharged from an acute Facility, about their discharge appeal rights.* Contracting hospitals are required to comply with the requirements set forth in these regulations.

The appeal rights give Medicare beneficiaries the right to an immediate review by a Quality Improvement Organization (QIO). QIO reviews are initiated by a Covered Individual or their representative when a decision is made by the Covered Individual's primary care physician (PCP), hospital or Plan to discharge the patient from a hospital stay that is no longer medically necessary, and the Covered Individual disagrees with the decision to discharge or discontinue inpatient services.

When admitted to the hospital, all Medicare beneficiaries will continue to receive the Important Message from Medicare, which explains their rights, including the right to appeal to the QIO if they believe they should not be discharged.

Issuing the Important Message From Medicare

1. The Important Message (IM) must be issued to all Covered Individual (beneficiary) within two calendar days of admission or not more than seven calendar days pre-admission. This is usually given to the Covered Individual's with their hospital admission papers (consent, etc), upon admission.
2. The IM notice should be delivered as far in advance as possible prior to discharge, but not more than two calendar days before the day of discharge.
3. Delivery on the day of discharge is allowed if discharge is unavoidable. (Allow at least 4 hours for the beneficiary to consider his/her discharge appeal rights).
4. Acute Facilities are responsible to document the appropriate and timely delivery of the notice.
5. No follow-up notice is required if the initial copy was delivered within two calendar days of discharge. *Admitted on Monday, delivered on Wednesday, discharged on Friday*.
6. Therefore, if the IM notice was issued on admission, and the Member stayed seven days, the IM notice has to be re-issued (the same notice originally issued can be used).

An IM is required:

1. Upon admission to an inpatient acute hospital
2. The Covered Individual is being discharged
3. The Plan (or hospital) is not discharging the Covered Individual, but no longer intends to continue coverage of the inpatient stay

IM: Delivery Process

1. The IM must be issued to the beneficiary within two calendar days of admission or not more than seven calendar days pre-admission.

2. The IM approved by Medicare (CMS-R-193) is required.
3. The beneficiary must be able to understand the IM.
4. The IM must be signed and dated by the beneficiary or their guardian, authorized representative or POA (if the POA is applicable).
5. Both the acute Facility and beneficiary retain a copy.

Inpatient to Inpatient Transfers

When transferring a beneficiary from one acute Facility to another (not discharged):

The receiving hospital would provide a new IM if the transfer involves different Medicare ID (Provider) numbers. No follow-up IM is needed prior to leaving the sending Facility. The hospital ultimately responsible for the discharge is responsible for the timely delivery of a follow-up IM.

Request for an Immediate Review/Appeal of the Discharge Notice

The Beneficiary or the Authorized Representative has the right to appeal or dispute the discharge notice.

If the Medicare beneficiary/representative disagrees with the discharge, the beneficiary/representative must contact the CMS contracted Quality Improvement Organization (QIO) to request an appeal and the Facility must issue a "Detailed Notice of Discharge" (DND) explaining the reason for discontinuation of services.

1. A DND is required only when:
   a. The beneficiary/representative **disagrees** with the discharge decision; or
   b. The Plan (or hospital) is not discharging the individual, but no longer intends to continue coverage of the inpatient stay and the beneficiary/representative **disagrees**.
2. The request must be made to the QIO no later than midnight of the day of discharge and must be made before the beneficiary leaves the acute Facility.
3. There is no beneficiary financial responsibility (other than co-pays/deductibles/co-insurance) for services provided before noon of the calendar day ***after*** the date the beneficiary received the notification of the determination from the QIO
4. The beneficiary should not be discharged if a review is requested.
5. The beneficiary (or authorized representative) should be available to discuss the case with the QIO.
6. The QIO will notify the Health Plan that a review has been requested.
7. The Health Plan will notify the acute Facility that a review has been requested.
8. The acute Facility will prepare the **Detailed Notice of Discharge** (DND) (CMS No. 0938-1019) and deliver this notice to the beneficiary or the authorized representative as stated previously.
9. The acute Facility must provide the QIO with all requested information including the DND, the current IM and the medical records, by noon of the next calendar day after the request from the Health Plan or QIO.
10. The QIO will issue its decision within one calendar day after it receives all requested information and notify the Plan, the acute Facility and the Member.
11. Failure to give needed information may result in a decision based on evidence at hand.

Timeframes for QIO Decision-making

1. Timely requests: 1 calendar day
2. Untimely requests (beneficiary still in acute Facility, but notice is not timely): 2 calendar days

Liability After Timely Request

1. If the QIO agrees with the discharge, the beneficiary's liability begins at noon of the day after the QIO decision notification
2. If the QIO disagrees with the discharge, the stay continues to be covered by the Health Plan (PMG/IPA).

No More NODMAR

The Notice of Discharge and Medicare Appeal Rights (NODMAR) is no longer valid.

Important Notes to Remember

1. The burden of proof lies on the Health Plan and their delegated entities (i.e., hospitals/contracted Providers) to demonstrate compliance with all aspects of this process
2. This process is a 24/7-365D process with no exceptions.
3. The Facility is responsible for issuance of both notices:
   a. **"Important Message From Medicare"** (IM) notice (CMS – R-193)
   b. **"Detailed Notice of Discharge"** (DND) notice (CMS No. 0938-1019)
4. The acute Facility must provide the QIO with all requested information including the DND, the current IM and the medical records, by noon of the next calendar day after the request from the Health Plan/QIO.
5. The Health Plan (PMG/IPA) is financially responsible for coverage of services during the QIO review.
6. If the QIO determines that the hospital did not deliver valid notices, the QIO will instruct the hospital to reissue a new notice and will proceed with the review.
7. QIO makes their determination based on criteria in section 1154(a) of the Act (SSA).
8. CMS websites:
   a. IM and DND are available at http://www.cms.hhs.gov/BNI/
   b. AOR is available at http://www.cms.gov/site-search/search-results.html?q=forms

Notifying Enrollees of Termination of Provider Services and the "Fast Track" Appeal Process

CMS regulations require that a two notice process be effective for all MA beneficiaries whose services are being terminated or discontinued from a HHA or Comprehensive Outpatient Rehabilitation Facility (CORF), or who are being discharged from Skilled Nursing Facility (SNF), when services and/or admission was preauthorized.

Prior to any termination of service, the Provider of the service must deliver standardized notice, the *Notice of Medicare Non-Coverage* (NOMNC) informing the enrollee of the PMG's or health plan's decision to terminate services, and a *Detailed Explanation of Non-Coverage* (DENC) notice if the enrollee disagrees with the termination of services.

A model of the NOMNC is located on the CMS site at http://www.cms.gov/bni/09_MAEDNotices.asp.

The Provider must notify the enrollee of the PMG/IPA's decision to terminate Covered Services no later than two days before the proposed end of the services, and issue the NOMNC (Advance Notice). If the enrollee's services are expected to be fewer than two days in duration, the Provider should notify the enrollee at the time of admission to the service/Facility. If the enrollee is in a non-institutional setting and the span of time between services exceeds two days, the notice should be given no later than the next to last time services are furnished.

The second notice, DENC (Detailed Notice) is only issued if the Covered Individual disagrees with the Advance Notice (NOMNC) and requests an appeal. This DENC notice is located on the CMS site at http://www.cms.gov/bni/09_MAEDNotices.asp.

If the Covered Individual wants to appeal, he or she must contact the CMS-contracted independent review entity, QIO, to request an appeal. For California, the QIO is Health Services Advisory Group (HSAG). When the QIO notifies the MA organization (Anthem Blue Cross) that a Covered Individual has requested an appeal, Anthem Blue Cross must issue a DENC notice to both the Covered Individual and the QIO no later than close of business the same day. Anthem Blue Cross will request records needed/requested by the QIO, prepare the DENC and fax it to the Provider to issue to the Covered Individual.
Providers must be able to provide Anthem Blue Cross with the requested information on the date of request, which includes weekends.

For Home Health Services:

The home health agency issues the NOMNC and the DENC. The QIOs will contact the HHA directly; when Anthem Blue Cross is notified by the QIO, Anthem Blue Cross will notify them of the appeals and provide instructions for forwarding records, copy of the NOMNC and DENC to the QIO. The HHA should also fax a copy of the NOMNC and DENC to Anthem Blue Cross.

Note: This process is a 24-hour, seven-day-a-week requirement – weekends included.

Expedited Appeal Request

In the event the Covered Individual misses the deadline for requesting immediate QIO review, the Covered Individual may still be entitled to an expedited appeal through Anthem Blue Cross.

Part-D Prescription Drug Appeals

Medicare now provides seniors and people with disabilities with the first comprehensive prescription drug benefit ever offered under the Medicare program. The Part-D Prescription Drug benefit became effective January 1, 2006, and is also regulated by the CMS. The Medicare Part-D Prescription Drug benefit plan (Part-D) is offered to Anthem Covered Individuals, through a contract with CMS.

Medicare's term for Part-D first level appeal is known as "redetermination," and this first level is handled by the Plan. The second-level appeal, which is handled by CMS' independent review entity (IRE), is known as "reconsideration."

A Covered Individual may use the redetermination procedure for disputes involving an adverse coverage determination (denial) rendered by Anthem and pertains to the following:

1. Any coverage determination that is denied (not to provide or pay for a Part-D drug) in full or partially by Anthem, that the Covered Individual believes may be a covered benefit, including:
   a. The decision not to pay because the drug is not on the Plan's Formulary
   b. The drug is determined not be medically necessary
   c. The drug is furnished by an out-of-network pharmacy
   d. The drug is otherwise excluded under *Section 1862(2)* of the *Medicare Act*, which is applicable to Medicare Part-D excluded drugs
2. Any coverage determination exception request that is denied in full or partially by Anthem as not medically necessary
3. A denial decision on the amount of cost-sharing for a drug, as applicable under *§423,578(b)* of the *Code of Federal Regulations*
4. Failure to provide a coverage determination in a timely manner, when a delay would adversely affect the health of the Covered Individual

Timeframes for Filing a Redetermination (Appeal) Request

A Covered Individual must file a request for a redetermination **within 60 calendar days** from the date of the notice of the coverage determination.

1. If the 60-day period in which to file a request for a redetermination has expired, an enrollee may file a request showing the following:
   - "Good Cause," with an explanation of why the request was not filed on time.
   - If the G&A staff cannot identify any good cause for the delay, a letter is sent to the Covered Individual or his/her representative denying the review of his/her appeal request, and advising him or her of the grievance process.
   - Any appeal request submitted more than one year from the date of the organization denial letter will not be accepted for review. A letter is sent to the Covered Individual or his/her representative advising him or her of the rejection of the appeal request for review and advising him/her of the grievance process.
2. This request must be submitted in writing.

Timeframes for Making Redetermination (Appeal) Decisions

A Part-D **standard appeal** must be resolved as expeditiously as required by the Covered Individual's health condition, but no later than seven calendar days from the date of receipt by Anthem Blue Cross. Standard appeals include both Pre-service and Post-service claim appeals (request for reimbursement). The **seven calendar-day** timeframe starts from receipt of the appeal by Anthem Blue Cross. If Anthem Blue Cross upholds the initial denial decision, the Covered Individual is notified in writing of the decision

and given his/her rights to further appeal to the CMS IRE. Unlike the medical appeal, Anthem Blue Cross does not automatically forward an appeal denial decision to the IRE.

However, if G&A fails to make a determination within the timeframes indicated above (seven days), it is considered an adverse determination and the case file must be forwarded to CMS's IRE, the Center for Health Dispute Resolution (CHDR), for review and determination, **within 24 hours of the expiration of the required adjudication timeframe**.

When this happens, a letter is sent to the Covered Individual or his/her representative advising him/her of the pending status of the appeal, that we are unable to resolve the issue during the mandatory timeframe, and that the case file is being forwarded to CMS's IRE for determination.

For claim appeals (request for reimbursement for a drug the Covered Individual already paid for and received) that are overturned (approved), G&A must reimburse or confirm reimbursement within 30 calendar days from the date the appeal was received, meaning 23 calendar days from the date of the overturn decision (seven plus 23 days).

A Part-D **expedited appeal** must be resolved as expeditiously as required by the Covered Individual's health condition, but no later than 72 **hours** after receiving the request.

If G&A fails to make a determination within the timeframes indicated above (72 hours), it is considered an adverse determination and the case file must be forwarded to CMS's IRE, the CHDR, for review and determination within 24 hours of the expiration of the adjudication timeframe.

Opportunity to Submit Evidence

Covered Individuals or their prescribing physicians, as appropriate, have the right to present additional information, evidence and allegations of fact or law, related to the issue in dispute, in person as well as in writing. In the case of an expedited redetermination, the opportunity to present evidence is limited by the short timeframe for making a decision. Therefore, this is accomplished at the point of contact by Customer Service.

Federal Employee Program (FEP) Reconsiderations and Appeals

FEP: Blue Shield of California will review and respond to appeals on professional claims, for services incurred in the state of California. Blue Cross of California will review and respond to appeals on Facility claims for services incurred in the state of California.

There are specific procedures for reviewing disputes of claims or pre service requests (such as prior approval or pre certification) under the Federal Employee Health Benefits program. The process has two steps, starting with a review by the local Blue Cross and/or Blue Shield plan (reconsideration), which may lead to a review by the Office of Personnel Management (OPM Appeals).

The review procedures are designed to provide Covered Individuals, or someone else duly authorized by the Covered Individual, with a way to resolve disputes of claims or Pre-service requests (such as prior approval or pre-certification), as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Covered Individuals, or their duly authorized representative. The local plan and OPM do not accept requests for review from physicians, hospitals, Facilities or other health care professionals, except on behalf of, and with the written consent

from, the contract holder or Covered Individual, or their duly authorized representative.

The physician, hospital, Facility or other health care professional is required to demonstrate that the contract holder or Covered Individual has assigned all rights to the physician, hospital, Facility or other health care professional for that particular claim or claims, or Pre-service requests.

Ancillary professional Providers may ask for reconsideration at the Blue Cross and/or Blue Shield plan level when they disagree with a Blue Cross and/or Blue Shield plan's benefit determination on claims or Pre-service requests.

Blue Cross and/or Blue Shield plan's response to the physician, hospital, Facility or other health care professional will include a statement indicating OPM's position on receiving additional appeal requests.

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 Blue Cross and/or Blue Shield plan that denied the service reviews the benefit determination on receiving a written request. This request must come from the Covered Individual, 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.

The local Blue Cross (institutional claims) and/or Blue Shield (professional claims) 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 Blue Cross and/or Blue Shield plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses' notes, related to the service. If the additional information is not received within 60 calendar days, the Blue Cross and/or Blue Shield 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 Covered Individual request, or if an adverse benefit determination is rendered, the Plan will advise the Covered Individual of his/her right to appeal to OPM.

Only the Covered Individual or contract holder, or duly authorized representative, may appeal to OPM, as outlined in Section 8 the Federal Employee Program Service Benefit Plan brochure.

Covered Individual Commercial Pharmacy Prior Authorization & Grievances and Appeals Process

Covered Individual and Practitioner Notice

When a drug is denied at point-of-sale due to a specific exclusion in the Covered Individual'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 Covered Individual.

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.

An Anthem Blue Cross physician advisor will approve the request if the additional information meets the predetermined medical criteria. If the predetermined medical criteria are not met, the Anthem Blue Cross physician advisor will deny the request. The reason for the denial and the name of the Anthem Blue Cross physician advisor will be included in the denial letter that is sent to the Covered Individual and requesting physician.

If the decision made by the Anthem Blue Cross physician advisor is unacceptable to the Covered Individual, he or she may appeal the decision. The appeal is forwarded to Anthem Blue Cross G&A Department for handling through the standard or expedited appeal process as appropriate to the clinical issue.

The Covered Individual or his/her physician may provide additional medical information in the appeal of a denied medication. An Anthem Blue Cross medical director or physician advisor 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 Covered Individuals and Providers on Adverse Pharmacy Determinations

When a final decision is made regarding a requested medication, the Covered Individual is sent written notification of this determination. If the reason for denial is due to a contractual exclusion, the Covered Individual 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 Covered Individual is sent a letter advising him or her of the denial, with information regarding the Covered Individual's appeal rights for IMR, 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 Covered Individual 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 Covered Individual will be sent a letter advising of the final outcome of their grievance issue. This may be a letter informing the Covered Individual 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 Blue Cross' executive team for analysis, tracking, trending and quarterly reporting to the Anthem Blue Cross Quality Committee.

Off-Label Prescription Drug Coverage

California 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.

Quality Improvement

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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 the strong local presence required to understand and meet customer needs. Our plans are well positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information to assist them in seeking quality care. Our local plan presence and broad expertise create opportunities for collaborative programs that reward physicians and hospitals for clinical quality and excellence. 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 our communities and is helping to address some of health care's most pressing issues. The Quality Improvement Program Description defines the quality infrastructure of our company that supports our improvement strategies.

- The Quality Improvement (QI) Program Description defines the quality infrastructure, establishes program governance, scope, goals, measureable objectives, and describes functional areas that support quality improvement strategies.
- Annually, a QI Work Plan is developed and implemented with the goal of improving the level of service and care provided to Covered Individuals. The QI Program also reflects ongoing progress on priority QI metrics.
- The QI Evaluation assesses the overall effectiveness of the quality improvement program, outcomes of the QI metrics defined on the QI Work Plan, and determines how the 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, and select the Providers link at the top of the landing page (under the "Other Anthem Websites" section). Select your state from the drop down list and click enter. 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 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 our Covered Individuals, Providers and Facilities.

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

Quality and Safety of Clinical Care

- Chronic Disease and Prevention: Anthem focuses on Covered Individual 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 Programs: Anthem focuses on improving the coordination between medical and behavioral health care, with programs specifically addressing conditions such as alcohol and other drug use, depression, attention deficit hyperactivity disorder, and bipolar disorder.

- Patient Safety: Anthem works with physicians, hospitals, and other health care Providers to help reduce adverse health care-related events and unnecessary cost of care, as well as to develop innovative programs to encourage improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient empowerment, care management and payment innovation.
- Continuity and Coordination of Care: Anthem's goal is to help improve continuity and coordination of care across physicians and other health care professionals through interventions that promote timely and accurate communication.

Service Quality: Anthem periodically surveys its Covered Individuals and uses other tools to assess the quality of care and service provided by our network Providers and practitioners. We also strive to provide excellent service to our Covered Individuals, Providers and Facilities. Anthem analyzes trends to identify service opportunities and recommends appropriate activities to address root causes.

Program Monitoring

To enable comprehensive assessment of the system and meaningful prioritization of initiatives, Anthem selects critical monitors from care management, disease management, network management, pharmacy management and medical management. The following program components are inherent to the promotion of quality medical and behavioral health care delivery and service:

Accessibility of Services	Medicare Plan (Star) Ratings
Availability of Practitioners	Member* Satisfaction/Experience and Provider Satisfaction
CAHPS®	Member, Practitioner and Provider Communication
Clinical Quality	Medical Record Audit
Complaints, Grievances & Appeals	Member Services
Continuity/Coordination of Care	Patient Safety
Contracting	Physician Quality
Credentialing/Recredentialing	Practice Guidelines for Medical, Behavioral Health and Preventive Care
HEDIS®	
Hospital Quality	Service Quality

CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

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

**Members are "Covered Individuals" of the Plan.*

Selection of other areas for monitoring and/or quality improvement projects are made by identifying areas of care and/or service that are high in volume, risk, or are problem prone. Selections are made on the probability that such review will have a positive impact on the health and well-being of the Covered Individuals. Selection may also be done through industry and business collaboration initiatives including health, state or business coalitions.

! For information about our QI program and its goals and performance, go to anthem.com/ca. Click on the green band "Anthem Difference." Select "Commitment to Quality and Safety." Scroll down to the Quality & Safety section and click "learn more."

! You can find out more about the Anthem Blue Cross QI program annual results and comparisons with other health plans on the websites of the California Cooperative Healthcare Reporting Initiative (CCHRI) and the State of California Office of Patient Advocate (OPA). Links to their websites can be found in our *Links* section of this Manual.

Access and Availability of Care

Anthem Blue Cross monitors appropriate Covered Individual access to care through a variety of different mechanisms including, but not limited to:

- Compile the rate of access and availability of care related to Covered Individual grievances and appeals at the plan level.
- Participate in an annual telephonic survey to assess physician office's compliance with appointment availability standards. The survey is sponsored by The ICE (Industry Collaborative Effort).
- Conduct 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.
- Use Covered Individual responses to the Consumer Assessment of Healthcare Provider and Systems (CAHPS®), a standardized Member satisfaction survey, access relevant questions to assess compliance with routine and urgent care standards.
- Aggregate ProviderAccess® standard compliance results at the plan level and share compliance outcome with the contracted physicians through direct mail and web-based *Professional Network Updates*.
- Assess the ratio of physicians and high-volume specialists per California ZIP code, using excel software to determine compliance with the Anthem Blue Cross availability standards.
- Assess the availability of physicians and high-volume specialists, using GeoAccess software to determine compliance with the Anthem Blue Cross availability standards.

Behavioral Health and EAP Access and Availability of Care

Anthem Blue Cross monitors Covered Individual access to care through a number of mechanisms including, but not limited to:

- The rate of Covered Individual grievances related to access and availability of care
- Annual telephone surveys of participating providers' offices to determine compliance with Anthem Blue Cross Access and Availability Standards for emergent, urgent, routine and after-hours care
    - Conduct an annual telephonic survey to assess Behavioral Health/EAP Provider offices' compliance with the after-hours care standards. In surveying after-hours care, the 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 Behavioral Health/EAP Provider after hours; and an expectation as to when a return call should be expected. These telephone survey results are compiled at the plan level and shared with participating providers in the *Anthem Blue Cross Behavioral Health Network Update.*
- Assessment of the ratio of Behavioral Health and EAP Providers per California ZIP code to our membership, using excel software to determine compliance with Anthem Blue Cross availability standards
- Assess the availability of Behavioral Health and EAP Providers, using GeoAccess software to determine compliance with the Anthem Blue Cross availability standards
- Use Covered Individual responses to a standardized Member satisfaction survey, access relevant questions to assess compliance with routine, urgent and after hours care standards.

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 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 Blue Cross expects every Anthem Blue Cross health care practitioner to instruct his or her office and after-hours answering service staff regarding emergencies. If the caller believes he or she is experiencing a life-threatening emergency, the caller should be instructed to dial *911*, or to go directly to the nearest emergency room. Answering machine instructions must also direct the Covered Individual to call *911* or go to the emergency room if the caller believes he or she is experiencing an emergency. If emergency service is authorized by the answering service or office staff, this authorization is considered binding and cannot be retracted at a later date.

Access Standards for Medical Professionals

Physicians are required to comply with Anthem Blue Cross' Commercial and Medicare Advantage access standards. The following are the access standards for the delivery of clinical care that is conducted face-to-face. These are consistent with the Department of Managed Health Care (DMHC) access and availability

standards. Medicare Advantage access standards for medical and behavioral professionals are included in separate tables.

Commercial Access Standards

Type of Care	Standard
Non-urgent appointments for Primary Care Physician (PCP)	Must offer the appointment within 10 business days of the request
Urgent Care appointments not requiring prior authorization	Must offer the appointment within 48 hours of the request
Non-urgent appointments with Specialist Care Physician (SCP)	Must offer the appointment within 15 business days of the request
Urgent Care appointments that require prior authorization	Must offer the appointment within 96 hours of the request
Non-urgent appointments for ancillary services (for diagnosis or treatment of injury, illness or other health condition)	Must offer the appointment within 15 business days of the request
In-office waiting room time *(this is an existing Anthem Blue Cross requirement and is not part of the DMHC Timely Access Regulation)*	Usually Members do not wait longer than 15 minutes to see a physician or his/her designee
After-hours Care	Member to reach a recorded message or live voice response providing emergency instructions, and for non-emergent (urgent) matters, information when to expect to receive a call back
Emergency Care*	Immediate access to Emergency Care
Member Services by Telephone. Access to Member Services to obtain information about how to access clinical care and how to resolve problems *(this is a plan responsibility and not a physician responsibility; and this also applies to our Behavioral Health Members*) Plan shall provide for the provision, 24 hours per day, 7 days per week, of triage and screening services by telephone	Reach a live person within 10 minutes during normal business hours (Plan standard: 45 seconds; Call abandonment rate < 5%) Member NurseLine available 24/7 – (screening waiting time does not exceed 30 minutes)

** Subject to prudent layperson regulation. See Emergency Access Standards.*

Access and Availability Standards for Ancillary Service Providers

The following are the access standards for the delivery of clinical care that is conducted face-to-face. These are consistent with the Department of Managed Health Care (DMHC) access and availability standards.

Type of Care	Standard
Emergency Care Instructions*	Members are directed to *911* or the nearest emergency room
Urgent Care (that does not require prior authorization)	Must offer the appointment within 48 hours of the Member's request
Urgent Care (that requires prior authorization)	Must offer the appointment within 96 hours of the Member's request
Non-urgent Appointments for Ancillary Services (for the diagnosis or treatment of injury, illness, or other health condition)	Must offer the appointment within 15 business days of the Member's request
Access to After-hours Care	Available 24 hours/7 days; Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Provider, and be informed when the call will be returned
Office Appointment Wait Times *(this is an existing Anthem Blue Cross requirement and is not part of the new DMHC Timely Access Regulation)*	Usually Members do not have to wait longer than 15 minutes after their scheduled appointment to see a Provider

** Subject to prudent layperson regulation. See Emergency Access Standards.*

Access and Availability Standards for Behavioral Health and EAP Providers

Physicians are required to comply with Anthem Blue Cross' Commercial and Medicare Advantage access standards.

The following are the access standards for the delivery of clinical care that is conducted face-to-face. These are consistent with the DMHC access and availability standards.

Type of Care	Standard
Emergency Care Instructions*	Members are directed to *911* or the nearest emergency room
Non-life Threatening Emergency Care	6 hours
Urgent Care (that does not require prior authorization)	48 hours
Urgent Care (that requires prior authorization)	96 hours
Routine Office Visit	15 business days (Psychiatrists) 10 business days (Non-physician Mental Health Care Providers) 5 business days (EAP)
Type of Care	**Standard**
Access to After-hours Care	Available 24 hours/7 days. Member to reach a recorded message or live voice response providing emergency care instructions, and for non-emergent (urgent) matters, a mechanism to reach a Behavioral Health/EAP Provider, and be informed when the call will be returned
Office Appointment Wait Times *(this is an existing Anthem Blue Cross requirement and is not part of the DMHC Timely Access Regulation)*	Usually Members do not have to wait longer than 15 minutes after their scheduled appointment to see a Behavioral Health/EAP Provider

** Subject to prudent layperson regulation. See Emergency Access Standards.*

Access for Non-emergent After-hours Care

Anthem Blue Cross expects every participating practitioner to provide a mechanism for Covered Individuals to be able to reach a behavioral health Provider after hours for a non-emergent (urgent) matter.

The following are acceptable mechanisms supporting 24 hours a day, seven days a week availability and/or coverage for Anthem Blue Cross Covered Individuals:

Psychiatrists:

- Psychiatrists shall have a pager/cell phone, answering service and/or answering machine available to Covered Individuals 24 hours a day, seven days a week, either connecting the Covered Individual directly with the psychiatrist, or providing instructions for reaching the psychiatrist or an on-call psychiatrist.

  IMPORTANT: The Covered Individual must be notified at the time of the call when the psychiatrist will return urgent, non-emergent calls, whether directed by the answering machine or a live person.

Therapists:

- Therapists shall have a pager/cell phone, answering service and/or answering machine available to Covered Individuals 24 hours a day, seven days a week, either connecting the Covered Individual directly with the therapist, or providing instructions for reaching the therapist or an on-call Provider.

  IMPORTANT: The Covered Individual must be notified at the time of the call when the therapist will return urgent, non-emergent calls, whether directed by the answering machine or a live person.

Additional Requirements

In addition to the requirements listed above, all participating practitioners will:

1. Make best efforts to return all routine calls from Covered Individuals within 24 business hours.
2. Coordinate with another participating Anthem Blue Cross Provider for coverage arrangements. The participating Provider shall make best efforts to have any nonparticipating covering Provider abide by the terms of the Anthem Blue Cross Agreement. See the *Rights and Responsibilities* section of this Manual for additional information.
3. Report Open/Closed practice status to Behavioral Health Network Relations immediately upon the practice status changing. See *Open or Closed Practice* in this section for additional information.

Open or Closed Practice

Anthem Blue Cross has the ability to maintain and manage open or closed practice information. Open or closed practice refers to a participating Provider's ability or inability to accept new Covered Individuals (patients). This information is useful to Covered Individuals and clinical staff when trying to schedule appointments with available Providers. Many potential Covered Individuals utilize the company's online Provider directory or *Find a Doctor* tool on Anthem Blue Cross' website at anthem.com/ca > Find a Doctor. Open or closed practice information is available to Covered Individuals on this online Provider directory.

As a reminder, all participating Providers agree to render medical services to any and all Covered Individuals until the participating Provider closes their practice and is no longer accepting new Covered Individuals (patients) from any of their contracted health plans and the participating Provider believes, in their reasonable professional judgment, that accepting additional Covered Individuals would endanger a Covered Individual's (patient's) access to continuity of care. To best serve Covered Individuals and Providers, participating practitioners shall give Anthem Blue Cross prompt written notice of such practice

closure. Practitioners must notify Anthem Blue Cross of changes immediately, but no later than, 30 calendar days from the change. These updates can be made by checking Box #1 on the *Practice Update Form*, by completing the top section of the *Practice Profile* form or submitting a signed and written notice. Both of the above mentioned forms may be found in the *Exhibits* section of this Manual.

Providing prompt written notice of practice closure applies to all practitioners including both Anthem Blue Cross Behavioral Health Network Practitioners and Anthem Blue Cross EAP Practitioners. Anthem Blue Cross EAP Practitioners should also notify Anthem Blue Cross by phone immediately whenever their practice is booked or unavailable due to vacations and/or leave of absence. Anthem Blue Cross also has the capability to maintain and manage office hours information for our EAP practitioners. EAP practitioners should promptly notify Anthem Blue Cross in writing of any changes to office hours.

Home Offices Not Permitted as a Practice Location

Home offices are not permitted as a practice location. In addition, practice locations that are within, attached to, or on the immediate premises of a home or residence are not allowed.

! *Exceptions to the Appointment Access Standards*

These exceptions apply to Anthem Blue Cross' Commercial Medical, Ancillary and Behavioral Health access standards.

Exceptions to the Appointment Access Standards
Preventive Care Services and Periodic Follow-up Care: Preventive care services and periodic follow-up care are not subject to the appointment availability standards. These services may be scheduled in advance consistent with professionally recognized standards of practice as determined by the treating licensed health care Provider acting within the scope of his or her practice. Periodic follow-up care includes, but is not limited to, standing referrals to specialists for chronic conditions, periodic office visits to monitor and treat pregnancy, cardiac or mental health conditions, and laboratory and radiological monitoring for recurrence of disease.
Extending Appointment Waiting Time: The applicable waiting time for a particular appointment may be extended if the referring or treating licensed health care Provider, or the health professional providing triage or screening services, as applicable, acting within the scope of his or her practice and consistent with professionally recognized standards of practice, has determined and noted in the relevant record that a longer waiting time will not have a detrimental impact on the health of the patient.
Advanced Access: The primary care appointment availability standard listed above may be met if the primary care physician's (PCP's) office provides "advanced access." "Advanced access" means offering an appointment to a patient with a PCP (or nurse practitioner or physician's assistant) within the same or next business day from the time an appointment is requested (or a later date if the patient prefers not to accept the appointment offered within the same or next business day).

Medicare Advantage Access Standards

The following monitoring standards are used to evaluate timely medical and behavioral health access to health services for Anthem's Medicare Advantage plans. Medicare Advantage standards are subject to federal regulation and oversight by CMS.

Type of Care	Standard
Regular and Routine Care Appointment	14 calendar days: Members report that they "Usually" or "Always" get a routine care appointment at a doctor's office or a clinic as soon as they think they need it; 60 calendar days for preventive care treatment
Consult/Specialty Referral	14 calendar days: Members report that they "Usually" or "Always" can easily get a specialist appointment
Urgent Care Appointments	48 Hours: Members report that they "Usually" or "Always" get an urgent care appointment as soon as they think they need it
Emergency Care Appointments*	Members have immediate access to emergency care
Access to After-hours Care	Available 24-hours a day; Members to reach a recorded message or a live voice response providing emergency care instructions and for non-emergent (urgent) matters, a mechanism to reach a physician or on-call designee outside of routine office hours
Office Appointment Wait Time	Usually Members do not have to wait longer than 15 minutes to see a physician or his/her designee

** Subject to prudent layperson regulation. See Emergency Access Standards.*

Medicare Advantage Behavioral Health Access Standards

Type of Care	Standard
Care for Non-life Threatening Emergency Care	Within 6 hours
Urgent Care	Within 48 hours
Routine Office Visit	Within 10 business days

Member Satisfaction/Experience

Member satisfaction/experience is measured annually at the plan level, using CAHPS® and Medicare CAHPS® Survey methodologies.

Overview of CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem's Covered Individuals about their experiences with Anthem's health plans in the past year. This includes Covered Individual'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 Covered Individual 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 Covered Individuals 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).

Overview of HEDIS®

HEDIS® *(Healthcare Effectiveness Data and Information Set)* is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used set of health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and Anthem requests that the records be returned within five (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 "Provider" home page at anthem.com/ca. Click on the "Provider" link at the top of the landing page (under the "Other Anthem Websites" section), then click enter. On the Provider home page under the "Health and Wellness" tab (on the blue toolbar), select the "Quality Improvement and Standards" link, then scroll down to "HEDIS Information".

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

Clinical Practice Guidelines (CPGs)

Anthem Blue Cross considers clinical practice guidelines (CPGs) to be an important component of health care. Anthem Blue Cross adopts nationally recognized CPGs, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. 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 using medical literature, professional standards, and/or expert opinions.

CPGs are not a substitute for the professional judgment of physicians or other health professionals. Further, while authoritative sources are consulted in the development of these guidelines, the practice guideline may differ in some respects from the sources cited. CPGs are made available to network Providers for all lines of business (unless otherwise noted), through committee meetings, Provider websites, newsletters and other communications as informational resources for Providers to assist in evidence-based clinical practice, setting Member goals for health improvement, and other clinical purposes. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research. CPGs are not used by the plan for Medical Necessity review. The health plan develops Medical Policies and UM Guidelines (Medical Policies) for this purpose.

Providers can access the up-to-date listing of the CPGs through the Internet. To access the guidelines, go to anthem.com/ca. Click on the *Providers* link at the top of the landing page (under the "Other Anthem Websites" section), then click enter. On the Provider Home page, under the "Health and Wellness" tab (on the blue toolbar) select or scroll to the "Practice Guidelines," then select the link titled, "Clinical Practice Guidelines."

With respect to the issue of coverage, each patient 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 supersedes the clinical practice guidelines.

Preventive Health Guidelines (PHGs)

Anthem considers prevention to be an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG), and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on medical literature, professional standards and/or expert opinions. We review the guidelines annually for content accuracy, current primary sources, new technological advances, and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Covered Individuals. PHGs are not a substitute for the professional judgment of physicians or other health professionals. Further, while authoritative sources are consulted in the development of these guidelines, the health guideline may differ in some respects from the sources cited. PHGs are made available to network Providers for all lines of business (unless otherwise noted), through committee meetings, Provider websites, newsletters and other communications as informational resources for Providers to assist in evidence-based clinical practice, setting Member goals for health improvement, and other clinical purposes. CPGs are not used by the plan for Medical Necessity review. The health plan develops Medical Policies and UM Guidelines (Medical Policies) for this purpose.

The current PHGs are available on our website. To access the guidelines, go to anthem.com/ca. Click on the "Providers" link at the top of the landing page (under the "Other Anthem Websites" section), then click enter. On the Provider Home page, under the "Health and Wellness" tab (on the blue toolbar) select or scroll to the "Practice Guidelines" then select the link titled "Preventive Health Guidelines."

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersede the preventive health guidelines.

Continuity and Coordination of Care

The Anthem Blue Cross QI program is an ongoing, comprehensive and integrative system, which features a number of monitors and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, and to enhance the quality, safety, and appropriateness of medical and behavioral health care services offered by network Providers. These include:

- Journey Forward program (developed by a collaborative among WellPoint, UCLA's Cancer Survivorship Center, the National Coalition for Cancer Survivorship, the Oncology Nursing Society, and Genentech) aims to establish a new standard of care for cancer survivors by enhancing patient and Provider understanding of the late effects of cancer treatment and survivorship and facilitating the use of *Survivorship Care Plans* (documents that include a treatment summary and guidance for follow-up care post cancer treatment) through a suite of technology tools for patients and Providers. This is a part of the broader goal to improve the long-term care for cancer survivors by enhancing the continuity and coordination of care between primary and oncology care during and after cancer treatment Providers.
- The Controlled Substances Utilization Management Program alerts physicians of their patients with ≥ 10 claims for controlled substances in a 90-day period and includes a list of the Covered Individuals' controlled substance prescriptions and prescribing physician to make sure care is being appropriately coordinated. The information provided to the physician is intended to complement his or her direct knowledge of the patient, allowing an increased opportunity to evaluate appropriateness of drug therapy, discontinue drug therapy that may no longer be necessary, coordinate drug therapy with other Providers and detect potentially fraudulent prescriptions.
- The Polypharmacy Program identifies Covered Individuals who have prescriptions in 10 or more therapeutic classes, from three or more unique prescribers in a 3-month period and aims to reduce injury and adverse events due to polypharmacy drug misadventures. Key features of the Polypharmacy Program include messaging to Providers about patient polypharmacy utilization and significant drug-drug interactions.
- Surveys to Assess Coordination of Care. Blue Cross conducts a survey with PCPs regarding their satisfaction with the timeliness of communication from other physicians and Facilities that treat patients. Part of this survey includes a section regarding communication with other behavioral health care Providers. Behavioral Health practitioners are also surveyed regarding satisfaction with care management, claims, customer service, and communication between PCPs and other Behavioral Health practitioners.
- Comorbid Medical Behavioral Health Program. The primary goal of the program is to provide Members who have chronic medical conditions with a comprehensive behavioral health case management program to address overall needs, support Members into appropriate levels of care and enhance treatment compliance. Behavioral Health staff promotes the coordination of care

between medical and behavioral health Providers for all consenting Members. The results of the symptom screenings are communicated to the PCP (or other community physician of Member's choice) as well as the referral source.

- Severe and Persistent Mental Illness (SPMI) Program. The primary goal of the Program is to provide Members who have chronic behavioral health conditions with a comprehensive behavioral health case management program to address overall needs, support Members into appropriate levels of care enhance treatment compliance and improve overall well-being. SMPI is defined a diagnosable mental, behavioral or emotional disorder (e.g., schizophrenia, bipolar disorder, major depression) that result in functional impairment that substantially interferes with or limits one or more major activities (e.g., maintaining interpersonal relationships, activities of daily living, self-care, employment, recreation). Behavioral Health staff promotes the coordination of care between medical and behavioral health Providers for all consenting Members. The results of the symptom screenings are communicated to the treating psychiatrist (or other community physician of Member's choice in cases where there is no active psychiatrist).
- Antidepressant Medication Management Program. In support of appropriate clinical practice, Anthem Blue Cross has this patient-focused intervention to promote optimal use of antidepressant medications. All California Covered Individuals who newly start an antidepressant medication receive an individualized educational mailing and a telephone call utilizing automated voice recognition (IVR) technology. The IVR call encourages Covered Individuals to stay on their medication and if they have questions or concerns, they are directed to the prescribing physician. When Covered Individuals are seven days late in refilling their antidepressant medication during the first 180 days of therapy, a late refill IVR reminder call is made. The prescribing physician is also notified via written communication of the Member's late refill.
- Transition Assistance Program. Refer to the *Medical Management Programs* section in this Manual to learn about our Transition Assistance programs.

Patient Safety

Patient safety is critical to the delivery of quality health care. Our goal is to work with physicians, hospitals and other health care Providers and Facilities to promote and encourage patient safety and to help reduce medical errors through the use of guidelines and outcomes-based medicine and promotion of the use of processes and systems aimed at reducing errors. Specifically, support will be provided for the medical and behavioral health care of our Covered Individuals through collaborative efforts with physicians and hospitals that include incentives based on quality metrics, public reporting of safety information to employers, Providers, Facilities and Covered Individuals to emphasize the importance of programs to reduce medical errors, and empowering consumers with information to make informed choices. Improving patient safety is dependent upon not only patient needs, but also upon informed patients and the global health care community's demand for respect and attention to clinical outcomes-based practices.

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 practitioner, such as a physician, or a health care organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care

measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including, but not limited to:

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

Medical Record Standards

The following are the Anthem Blue Cross medical record standards:

Completing the Medical Record Review Process

Anthem Blue Cross Plans (the "Plans") recognize the importance of medical record documentation in the delivery and coordination of quality of care. The Plans have standards that require practitioners to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

Medical record audits/reviews are performed annually on a percentage of randomly chosen primary care physicians (PCPs) contracted for the Anthem Blue Cross' managed care products. 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.

Chart Elements/Content and Clinical Documentation

This section of the audit, which is completed for all reviews, monitors the quality of medical record documentation. The reviewer indicates Standard Met, Opportunity for Improvement or *Not Applicable (N/A)* for each of the criteria, as appropriate. 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 practitioner fails to meet the Plans' standard of 80 percent, a re-review is conducted within six months. Should the practitioner continue to score less than 80 percent on the medical record review, the practitioner would be put on corrective action that could result in termination from the network.

Chart Criteria Guidelines

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. A problem list is maintained and updated for significant illnesses and medical conditions.
5. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.
6. History and physical exam documentation identifies appropriate subjective and objective information *pertinent* to the patient's presenting symptoms, and treatment plan documentation is consistent with findings.
7. 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).
8. Documentation of Advance Directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent part of the medical record for adult patients are encouraged.
9. Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty) and/or Facilities if there is reference to referral or care provided elsewhere. The clinical review will look for a summary of findings or discharge summary in the medical record. Examples include progress notes/report from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing/Provider reports.
10. Age appropriate routine preventive services/risk screening is 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.

Member Rights and Responsibilities

The delivery of quality health care requires cooperation between Covered Individuals, their Providers and Facilities, and their health care benefit plans. One of the first steps is for Covered Individuals, Providers and Facilities to understand Member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement, which can be accessed by going to anthem.com. Select the "Providers" link at the top of the landing page (under the "Other Anthem Websites" section), then click enter. Select the "Health & Wellness" tab, then the link titled "Quality Improvement and Standards." If Covered Individuals need more information or would like to contact us, they are instructed to go to anthem.com and select "Customer Support," then Contact Us. Or they can call the Member Services number on their ID card.

For more information regarding our Quality Improvement Program

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 at the top of the landing page (under the "Other Anthem Websites" section), then click enter. On the Provider Home page, under the "Health & Wellness" tab (on the blue toolbar) select "Quality Improvement and Standards."

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Credentialing Scope

Anthem credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors and optometrists providing services covered under the Health Benefits Plan, and doctors of dentistry providing health services covered under the Health Benefits Plan including oral maxillofacial surgeons.

Anthem also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master's level clinical social workers who are state licensed; master's level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified or registered by the state to practice independently. In addition, medical therapists (e.g., physical therapists, speech therapists and occupational therapists) and other individual health care practitioners listed in Anthem's Network directory will be credentialed.

Anthem credentials the following Health Delivery Organizations (HDOs): hospitals; home health agencies; Skilled Nursing Facilities (SNFs) (nursing homes); free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health Facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

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 chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two Participating Practitioners, including one who practices in the specialty type that most frequently provides services to Anthem Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem Network Management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner's credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. 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 Providers.

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.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. 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.

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 Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and recredentialing 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 its 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 Data source is utilized. CAQH is building 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 Covered Individuals
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 certificates • The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals. Practitioners who see Members in more than one state must have a DEA/CDS 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

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 (HDOs)

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 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 or the appropriate state oversight agency performed 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. Covered Individual/Customer Services Departments
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem Departments
8. Any other verified information received from appropriate sources

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 recredentialing 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 Covered Individuals. 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 and/or Healthcare Integrity and Protection Data Bank (HIPDB). 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 and the HIPDB Guidebook, the process set forth in the NPDB Guidebook and the HIPDB 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. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals;

B. 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 Covered Individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS for each state; and

C. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

D 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 or 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.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at The Joint Commission (TJC), National Integrated Accreditation for Healthcare Organizations (NIAHO) or 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 hospital 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;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
9. 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 Covered Individuals. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS for each applicable state.

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

   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 certificate is obtained.
   c. The applicant agrees to notify Anthem upon receipt of the required DEA.
   d. Anthem will verify the appropriate DEA/CDS via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network.
      ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria 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 certificate is obtained;

(c) The applicant agrees to notify Anthem upon receipt of the required DEA;

(d) Anthem will verify the appropriate DEA/CDS via standard sources; applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network; AND

(e) Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of, or current use of, illegal drugs or history of, or current, alcoholism;
12. No impairment or other condition, which would negatively impact the ability to perform the essential functions in their professional field.
13. 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.
14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past ten (10) years of malpractice case history is reviewed.
16. Meets Credentialing Standards for education/training for 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;
17. No involuntary terminations from an HMO or PPO;
18. 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 recredentialing application and required attachments that must not contain intentional misrepresentations;
2. Recredentialing application 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;
4. No evidence of potential material omission(s) on recredentialing application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
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 OIG and OPM reports or on NPDB report);
10. Current DEA, CDS Certificate 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 Covered Individuals 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 Provider or Facility that does 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 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 Certificate, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals.
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

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 or the appropriate state oversight agency. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual 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 of 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 Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS or state site 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:

1. Hospital: Must be accredited by TJC, NIAHO or HFAP (formerly referred to as AOA Hospital Accreditation Program)
2. Ambulatory Surgery Center: Must be accredited by TJC, HFAP, Accreditation Association for Podiatric Surgical (AAPSF), Accreditation Association for Ambulatory Health Care (AAAHC), American Accreditation of Ambulatory Surgery Facilities (AAAASF), or Institute for Medical Quality (IMQ).
3. Home Health Care Agency: Must be accredited by TJC, Community Health Accreditation Program (CHAP) or Accreditation Commission for Health Care (ACHC).
4. Skilled Nursing Facility: Must be accredited by TJC or CARF.
5. Nursing Home: Must be accredited by TJC.
6. Free Standing Cardiac Catheterization Facilities: Must be accredited by TJC or HFAP (may be covered under parent institution).
7. Lithotripsy Centers: Must be accredited by TJC.
8. Behavioral Health Facility:
   a. The following behavioral health Facilities must be accredited by TJC, HFAP, NIAHO or CARF, as indicated.
      i Acute Care Hospital – Psychiatric Disorders (TJC, HFAP or NIAHO)
      ii Residential Care – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF)
      iii Partial Hospitalization/Day Treatment – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF for programs associated with an acute care Facility or residential treatment Facilities)
      iv Intensive Structure Outpatient Program – Psychiatric Disorders (TJC, HFAP or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents or CARF if program is a residential treatment center providing psychiatric services)
      v Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation (TJC, HFAP or NIAHO)
      vi Acute Inpatient Hospital – Detoxification Only Facilities (TJC, HFAP or NIAHO)
      vii Residential Care – Chemical Dependency (TJC, HFAP, NIAHO or CARF)
      viii Partial Hospitalization/Day Treatment – Chemical Dependency (TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)
      ix Intensive Structure Outpatient Program – Chemical Dependency (TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse

and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)

A. MEDICAL FACILITIES

Facility Type (MEDICAL CARE)	Acceptable Accrediting Agencies
Acute Care Hospital	TJC, HFAP, NIAHO, CIQH, CTEAM
Ambulatory Surgical Centers	TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ
Free Standing Cardiac Catheterization Facilities	TJC, HFAP (may be covered under parent institution)
Lithotripsy Centers (Kidney stones)	TJC
Home Health Care Agencies	TJC, CHAP, ACHC, CTEAM
Skilled Nursing Facilities	TJC, CARF, BOC Int'l
Nursing Homes	TJC, BOC Int'l

B. BEHAVIORAL HEALTH

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies
Acute Care Hospital – Psychiatric Disorders	TJC, HFAP, NIAHO, CTEAM
Residential Care – Psychiatric Disorders	TJC, HFAP, NIAHO, CARF, COA,
Partial Hospitalization/Day Treatment – Psychiatric Disorders	TJC, HFAP, NIAHO, CARF for programs associated with an acute care Facility or residential treatment Facilities
Intensive Structured Outpatient Program – Psychiatric Disorders	TJC, HFAP, NIAHO, COA for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents CARF if program is a residential treatment center providing psychiatric services
Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation	TJC, HFAP, NIAHO
Acute Inpatient Hospital – Detoxification Only Facilities	TJC, HFAP, NIAHO
Residential Care – Chemical Dependency	TJC, HFAP, NIAHO, CARF, COA

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies
Partial Hospitalization/Day Treatment – Chemical Dependency	TJC, NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents
Intensive Structured Outpatient Program – Chemical Dependency	TJC, NIAHO, COA for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents

HIV/AIDS Specialists

Procedure

1. All HIV medical practitioners (MDs) and doctors of osteopathy (DOs) will be credentialed and recredentialed in accordance with approved Anthem Blue Cross Credentialing Policies and Procedures. The minimum credentialing requirements for HIV specialists are as follows:
   a. Possess a current, valid, unencumbered, unrestricted California medical license.
   b. Possess a current, valid, unrestricted DEA Certificate, if applicable.
   c. Have malpractice insurance.

Pharmacy Program and Guidelines

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Prior Authorization of Pharmacy Benefits Process (Commercial)

Anthem Blue Cross reviews pharmacy utilization trends on a quarterly basis to identify medications that may be appropriate candidates for Prior Authorization of Benefits (PAB). These select medications are available through the Anthem Blue Cross PAB Program.

For each program, criteria and medical guidelines are established and approved by the Pharmacy and Therapeutics (P&T) Committee, which consists of practicing physicians and pharmacists. This external oversight ensures that the guidelines reflect community prescribing standards, while adding to the value of the prescription drug benefit. If a medication is prescribed for "off-label" use in the treatment of an illness that is life-threatening or chronic and debilitating, Anthem Blue Cross has a policy to allow coverage of such use of medication with the appropriate clinical evidence.

Similarly, some drugs are best used after other effective, and usually less expensive, drugs have been tried first (first-line therapy). These agents are noted as Step-therapy products. When a prescription for a Step-therapy product is presented to the dispensing pharmacy, the online claims processor will search the patient's recent paid claims profile for first-line therapy. The claim will be processed automatically if recent first-line therapy is found. If a first-line therapy is not found, the claim will be rejected and the dispensing pharmacist should either call the plan or the physician to discuss alternative prescription options. Finally, a small number of drugs may be limited to use in certain age or gender groups, and may have to go through the PAB process for benefit coverage.

Prescription drug PAB requests should be faxed to the prescription drug plan prior authorization center at 888-831-2243. Urgent PAB requests are initially reviewed within 24 hours of receipt, and non-urgent PAB requests within two business days if the prescription drug plan prior authorization center has received all of the information required. If additional information is required or the information submitted does not meet the approval criteria, a final decision will be made within five business days of the receipt of the request (72 hours for urgent requests).

Prescribing physicians are notified within 24 hours of the decision while Covered Individuals are notified within two business days. In the event that a PAB request is denied, a letter is sent to the prescribing physician explaining the medical reason(s) for the denial and naming the Anthem Blue Cross physician who issued the denial.

Information on the Anthem Blue Cross grievance and appeal process is provided in the letter to the physician, as well as in the letter sent to the Covered Individual. The Anthem Blue Cross PAB process is monitored regularly to secure timely outcomes. In emergency cases, or life-threatening situations, a 72-hour supply of medication may be dispensed.

The prescription drug plan prior authorization center is responsible for processing initial PAB requests for Anthem Blue Cross Covered Individuals. In some cases, requests are submitted without the information necessary to make a decision. When this occurs, the prescribing physician may be asked to provide additional medical information to the prescription drug plan prior authorization center in order to proceed with the review within 45 days. No decision will be made until additional information is received or the 45-day time period has expired. If the requested information is not provided in the required timeframe, a determination will be made based on the information available. Contact the prescription drug plan prior authorization center at 888-831-2242 to obtain the status of a PAB request.

To obtain *Prior Authorization of Benefits Request* forms or for a list of PAB medications, contact the prescription drug plan customer service center at 800-700-2541.

Under SB 866, the Department of Insurance and the Department of Managed Health Care developed a uniform Prior Authorization form and will implement SB 866 effective October 1, 2014 for fully-insured Members regardless of the state where the Member resides, the state where the Provider is located, or the state where services are provided. For fully-insured Members, upon implementation of the plan, or delegated medical group must notify the prescribing Provider within two business days of receipt of a completed Request Form that:

(A) The prescribing Provider's request is approved;

(B) The prescribing Provider's request is disapproved as not medically necessary or not a covered benefit;

(C) The prescribing Provider's request is disapproved as missing material information necessary to approve or disapprove the request;

(D) The patient is no longer eligible for coverage; or

(E) The request was not submitted on the required form, and must be resubmitted using the approved Request Form with the complete information required for consideration of the drug request. When additional information is being submitted or resubmitted specifically as part of a reconsideration of a recent previously denied request, the complete information required for consideration must be resubmitted as well. This can be achieved by including the originally submitted SB 866 form together with the additional information being submitted for reconsideration of the original request or by submitting a newly prepared SB 866 form that includes the required additional information for the reconsideration. Reconsiderations will follow the same timeframe for completion as any request submitted on a SB 866 form.

For operational ease, Anthem Blue Cross will also allow use of the CA Pharmacy Prior Authorization form for Members of all other funding types. For all other funding types, existing decision response times will remain.

Prior Authorization of Pharmacy Benefits Process (Medicare Part D)

For Medicare Part D (Medicare D), the process for reviewing pharmacy utilization trends and for the development of each pharmacy program is similar to those described in the previous subsection titled, *Prior Authorization of Pharmacy Benefits Process (Commercial)*. However, according to the regulations put forth by the Centers for Medicare & Medicaid Services (CMS), there are some differences in the timelines and processes for coverage determination.

Anthem Blue Cross has developed a coverage determination process, which includes an exception process and appeals processes that provide Covered Individuals with the opportunity to challenge the exclusion of a particular drug from a plan's Formulary; the placement of a drug on a higher cost-sharing tier; or have a drug approved through PAB.

PAB reviews are received by the prescription drug plan prior authorization center at 800-203-0267. Urgent PAB requests are reviewed and determined within 24 hours of receipt, and non-urgent PAB requests within 72 hours. For decisions made on non-urgent requests, physicians are notified via fax and Covered Individuals are notified via U.S. mail. For decisions made on urgent requests, physicians and Covered Individuals are initially notified orally, followed by a written notification within three calendar days.

For Covered Individuals requiring tiering exceptions or non-Formulary exceptions, similar processes apply as in Medicare D PAB request approval.

To obtain a *Prior Authorization of Benefits Request form*, please contact the prescription drug plan prior authorization center at 800-203-0267.

Note: The list of PAB drugs for Medicare D is different from the commercial Formulary's list of PAB drugs.

Pharmaceutical Management (Commercial and Medicare Part D)

Based on consideration of published clinical studies, data from the Food and Drug Administration (FDA), community standards, and cost/benefit evaluation, Anthem Blue Cross' Formulary is a dynamic tool that promotes rational and evidence-based prescribing.

The Prescription Drug Formulary is a list of prescription drugs that are covered by Anthem Blue Cross. Coverage for most of these medications is available through the pharmacy benefit. For quality assurance and pharmacotherapy advancements, the Formulary is updated quarterly by the P&T Committee. Formulary revision is based on objective evaluation of the efficacy, safety and value of reviewed medications.

The Medicare D benefit, on the other hand, has several different formularies. The formularies have been approved by CMS and the P&T committee. And, whenever a Formulary change is made that may negatively affect Covered Individuals (e.g., change to the Formulary, cost sharing or tiers), Anthem Blue Cross will provide notice to affected individuals 60 days in advance of the change. A transition process is required when a Covered Individual first enrolls in our Anthem Blue Cross Medicare D program in accordance with CMS transition guidance. (See subsection titled, *Prior Authorization of Pharmacy Benefits Process (Medicare Part D)*.

The Anthem P&T process is used to apply evidence-based medicine that is applicable to the senior population for our Medicare D product. And, in order to meet CMS requirements, an additional Medicare subcommittee has been established to review new drugs (i.e., 90 days to review new drugs and 180 days to make a decision) and place edits on certain medications.

For a copy of the formularies, you can access the Anthem Blue Cross website at anthem.com/ca for the commercial Formulary and medicarerx.anthem.com for the Medicare D formularies, or call Customer Service at 800-700-2541 for commercial Covered Individuals, and 800-928-6201 for Medicare D Covered Individuals.

The Preferred Drug Program and Exception Process

To promote the affordability of the pharmacy benefit, Anthem Blue Cross developed the Preferred Drug Program (PDP). Flexible and sensitive to patient needs, this program requires the active participation of the physician and the pharmacist to be successful. Ultimately, the PDP seeks to minimize the prescribing of specific non-preferred prescription drugs and direct those prescriptions to more preferred medications.

The plan always defers to the physician's decision. If a patient requires a non-preferred medication, it can be obtained through the PAB Program, or the prescribing physician can denote "dispense as written" (DAW) on the written or verbal prescription. However, for a select number of drugs (e.g., growth hormones, sexual dysfunction medications and onychomycosis agents), the physician will be directed to the PAB Program.

For more information on the PDP, call the toll-free number listed on the Covered Individual's ID card or access the Anthem Blue Cross website at anthem.com/ca.

Newly FDA-approved drugs will be added to the PDP as non-preferred drugs, pending review by the P&T Committee.

Medicare D Covered Individuals do not participate in the PDP.

Disclosure of Formulary Medications

Anthem Blue Cross provides physicians with quarterly updates of the medications that are included on the Formulary via the web and Provider newsletters. For an abbreviated list of medications on the Formulary, Covered Individuals can call Customer Service at the toll-free telephone number listed on their ID card or access the Anthem Blue Cross website at anthem.com/ca.

This quarterly update is not applicable to Medicare D benefits; however, the Medicare D Formulary website is updated regularly.

Quantity Supply Limits

Most pharmacy benefits allow up to a 30-day supply of medication in exchange for an out-of-pocket expense (e.g., copayment or coinsurance). This program defines a quantity limit based on FDA dosing recommendations. If a medical condition warrants a greater supply than what is recommended, then PAB will ensure access to a medically appropriate quantity. Prior to being dispensed, medications in this program require an internal review by Anthem Blue Cross.

For more information on the Quantity Supply Program, call the toll-free number listed on the Covered Individual's ID card or access the Anthem Blue Cross website at anthem.com/ca.

Dose Optimization

The Dose Optimization Program, or dose consolidation, is an extension of the Quantity Supply Program and helps increase patient adherence to drug therapies. This program works with the Covered Individual, the Covered Individual's physician or health care Provider, and the pharmacist to replace multiple doses of lower-strength medications, where clinically appropriate, with a single dose of a higher-strength medication (only with the prescribing physician's approval). For more information on Dose Optimization, call the toll-free number listed on the Covered Individual's ID card or access the Anthem Blue Cross website at anthem.com/ca.

Copayment Structure

Anthem Blue Cross offers a variety of pharmacy benefits that include Covered Individuals' out-of-pocket expenses, including deductibles, copayments and/or coinsurance. When picking up medication(s) at a retail

pharmacy or when ordering medication(s) through mail order, Covered Individuals pay a copayment at the point of sale. Specific copayment structures vary depending on the particular product under which the Covered Individual is covered.

For Covered Individuals with Medicare D benefit, their copayment/coinsurance/deductible amounts will vary depending on several factors including: type of Formulary, place of residence, type of medication, availability of additional source of coverage, incurred cumulative true out-of-pocket (TrOOP) costs and the type of pharmacy where medication is dispensed.

Covered Individuals may refer to their *Evidence of Coverage* (EOC) for additional information regarding their plan's copayment structure. To verify eligibility and a Covered Individual's pharmacy benefit, call the toll-free number listed on the Covered Individual's ID card.

Other Drug Programs

Subject to benefit design, other pharmacy programs may apply to a Covered Individual's prescription drug benefit. Direct Covered Individuals may contact an Anthem Blue Cross Customer Service representative or consult their EOC for an explanation of which programs may apply to them.

Access to Non-Formulary Medications

The Drug Utilization Review (DUR) exception process provides access to most non-preferred and non-Formulary medications, multisource brands, therapeutic interchanges and Step-therapy procedures for select benefit plans.

When the prescribing physician denotes "do not substitute" (DNS) or "dispense as written" (DAW) on the prescription, the pharmacist transmits the claim using the appropriate DUR code to allow adjudication of that claim. Select non-Formulary medications are channeled through the PAB process through which an internal review is required prior to being dispensed.

Medicare Part D benefits use a Formulary annually approved by the CMS. There is an exception process to allow coverage of non-Formulary medications if the Covered Individual is unable to switch to a Formulary agent during the transition phase.

For Medicare D Covered Individuals who require access to non-Formulary medications, all requests need to be channeled through the PAB process where an internal review is required prior to dispensing. And for Covered Individuals who are enrolling to the Anthem Blue Cross Medicare D program for the first time, access to non-Formulary medications, based upon the mandatory CMS transition guidance, will be available for those who qualify for up to 90 days.

For a copy of the Formulary, access the Anthem Blue Cross website at anthem.com/ca or call the toll-free number listed on the Covered Individual's ID card.

Specialty Drug Fulfillment

Specialty Drugs are typically high-cost, injectable, infused, oral or inhaled Drugs that generally require close supervision and monitoring of their effect on the patient by a medical professional. Certain specified Specialty Drugs may require special handling, such as temperature controlled packaging and overnight delivery.

Anthem Blue Cross dedicated teams manage our integrated specialty pharmacy benefit focused on managing the total health care needs of our Covered Individuals. Our approach optimizes adherence and appropriateness of care, supports the physician/patient relationship and plan of care, reduces waste and total health care costs, includes comprehensive care management plan, utilization management (UM) and case management (CM), to ensure the Covered Individual is treated in the appropriate setting – outpatient hospital, clinic, doctor's office or at home.

In addition, specialty medications can be covered under both pharmacy and medical benefit. Subsequently, it is important to always verify Covered Individual's eligibility and benefit coverage.

If Covered Individual's have questions regarding specialty medications covered under their outpatient prescription drug benefit, please refer them to the health plan website at anthem.com/ca or to the phone number on the back of their ID card.

If Providers have questions about specialty medications covered under the Covered Individual's outpatient prescription drug benefit they may call the customer service number on the back of the Member's ID card or they may visit our website at anthem.com/ca.

Pharmacy Benefit Coverage

For specialty medications covered under a Covered Individual's outpatient prescription drug benefit, Anthem Blue Cross applies utilization edits to specialty pharmacy drugs and utilizes the clinical programs to minimize wastage and promote patient compliance. Dependent upon benefit coverage, Covered Individuals can either pick up these medications at their local retail pharmacy or they can be delivered to their home or physician's office from our preferred specialty pharmacy.

Specialty Pharmacy Program

Some Covered Individuals may be required to use our preferred specialty pharmacy vendor to obtain their specialty medications per their Evidence of Coverage (EOC) Guidelines.

Covered Individuals cannot get these specialty drugs from participating retail pharmacies. The list of drugs is not a guarantee of coverage; please refer Covered Individuals to their benefit booklet for specific coverage information. This list is subject to change; please visit our website for updates.

Oncology adjunct drugs given as part of a chemotherapy regimen do not have to be obtained through our preferred specialty pharmacy. These drugs may be subject to pharmacy prior authorization requirements.

Our specialty pharmacy preferred pharmacy will deliver medication by mail or common carrier. Most specialty drugs on our specialty pharmacy program list are limited to a 30-day supply. Covered Individuals and Providers can review this list online or by calling customer service teams for assistance.

The online specialty pharmacy drug list and Formulary are located in the "Forms Library" on anthem.com/ca.

To navigate to the Forms Library (either before or after logging in to anthem.com/ca):

- On the Customer Support link located on the homepage, select "Download Forms." Or visit the Download Forms Link at: www.anthem.com/ca/health-insurance/customer-care/forms-library

- Select the Specialty Drug List to review medications required to be dispensed under the specialty pharmacy program.
- The Covered Individual may also request their physician complete the specialty pharmacy Exception form and follow the process in the event the Covered Individual may experience a hardship using Anthem Blue Cross specialty pharmacy program. This form is also available on the Download Forms Library.

4th Tier Benefit

Some Covered Individual's employer groups have elected our 4th tier specialty benefit coverage. The changes will take place upon employer renewal.

Tier 4 – Specialty drugs that are used to treat complex, chronic conditions and may require special handling and/or management are on this list. For Covered Individuals who do not have a Tier 4 plan, these drugs are found under Tier 1, 2 or 3.

Medical Benefit Coverage

Specialty drugs covered under the Covered Individual's medical benefit can be obtained through our Network specialty Providers or physicians may also continue to buy and bill and have the option to use our online Provider portal to allow real-time prior authorization for some specialty drugs.

If Covered Individuals have questions regarding specialty medications covered under their medical benefit, Covered Individuals should contact their assigned customer service group at the toll-free phone number listed on the back of their health plan ID card or visit the health plan website.

If Providers have questions about specialty medications covered under the Covered Individuals medical benefit they may call our Utilization Management (UM) Intake team directly at 800-274-7767, option #2 for eligibility, benefits or claims and/or option #4 for specialty pharmacy preauthorization, or they may visit our website at anthem.com/ca or use our secured ProviderAccess portal to confirm eligibility, verify coverage or check claims status.

When benefits are provided for specialty drugs under the patient's medical benefits, they will not be provided under the patient's prescription drug benefit, if included. Conversely, if benefits are provided for specialty drugs under the patient prescription drug benefit, if included, they will not be provided under the patient's medical benefit.

Pre-service Medical Review

For additional detail, refer to the *Specialty Pharmacy Program* subsection within this section of the Manual or contact our Specialty Pharmacy Medical Management team directly at 866-580-5293 (phone) or 866-408-7195 (fax).

Workers' Compensation

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Medical Provider Network

The Workers' Compensation Reform Legislation, SB 899, was enacted to address many of the primary cost drivers and related issues regarding the State of California's Workers' Compensation system. This bill allows MPN Applicants (self-insured employers, insurance carriers, and now Entities Providing Physician Network Services with the adoption of the SB 863 regulations effective 8/27/14) to submit a list of participating medical Providers to be included in their Medical Provider Network (MPN) for use by injured workers. The MPN Applicant has the exclusive right to determine the participating Providers in its MPN.

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 Prudent Buyer Network. By participating in an MPN, injured workers will be channeled to you for treatment, which includes referrals to our other contracted participating Providers, hospitals, ambulatory surgery centers, laboratories, ancillary networks and Behavioral Health networks within Anthem Workers' Compensation. Insurance carriers, Self-Insured Employers and Entities Providing Physician Network Services who have selected you to participate in their MPN will have control of medical direction and channeling of an injured worker's care to MPN physicians for the entire life of the claim.

The Anthem Blue Cross EAP Network will not receive referrals for injured workers who are also covered under an Anthem commercial health plan. In the event this occurs, the Anthem Blue Cross EAP Practitioner shall refer the injured worker back to the employer or claims adjuster for their work-related injury or illness.

To confirm your MPN status, please contact the insurer or employer directly prior to performing services. If you do not wish to participate in a specific MPN you have the right to "opt out" as described later in this Manual.

Maintaining Your Anthem Workers' Compensation Network and/or MPN Status

To ensure you and/or your group are correctly listed in the directory and available to be selected for an MPN, please follow the steps below. If these steps are not followed, 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 of participating physicians that treat Workers' Compensation (if applicable) as only Providers listed in the directory can be part of an MPN. Further, SB 863 MPN Regulations state any Medical Group that wishes to participate in the MPN shall maintain and update the active roster of physicians associated with the Medical Group and report any additions, terminations or demographic changes. You can report changes in roster information directly to WCRosters@anthemwc.com. If you leave a group and do not have a contract for your new TIN (Tax ID Number), you may experience a gap in your participation.
2. If you leave a group that has delegated credentialing and are part of another participating group, if that group is not approved by Anthem to have delegated credentialing, you must initiate CAQH/Credentialing with Anthem within 60 days of leaving the delegated group to continue your participation. To do so please email CAcontractsupport@anthem.com or call MPN Services at

866-700-2168 and they will connect you. You must receive Anthem credentialing/recredentialing approval to maintain network and MPN participation.

3. If you add or change a specialty, you must contact Anthem to have the Credentialing Department process your change before it can be updated on your Provider directory listing.
4. If you are unable to accept new patients, you must refer them within the MPN to a participating Provider (see section "Physician Referrals within the Anthem Workers' Compensation Network or Other Payor MPN.") Help in doing so can be obtained by contacting the MPN Services department at 866-700-2168.
5. If you do not treat Workers' Compensation patients, please contact our MPN Services department at 866-700-2168.

If you choose to terminate your participation in the Workers' Compensation Network by terminating your contract, not renewing your credentialing status, opting out 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 you renew your contract, renew your credentialing status, opt back in or update your directory data, this will reinstate you into the Anthem Workers' Compensation Network. ***However, this does not automatically reinstate you into the insurer's, employer's, or Entities Providing Physician Network Services' MPN. You should contact the client or MPN Services to confirm if you will be reinstated in each MPN you previously participated.***

MPN Regulations, Provider Selection, Referrals and Authorized Treatment

The DWC has established MPN regulations for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. If you have been selected as an MPN Provider you must adhere to the guidelines below in order to assist the MPN in providing for the injured worker's medical needs and maintaining medical control for the life of the claim:

- **Refer within the MPN.** For employers and carriers accessing the Anthem Blue Cross Prudent Buyer Network for Workers' Compensation, this means referrals **must be made to Providers participating in the Anthem Workers' Compensation Network that are included in the MPN**. Contact our MPN Services department at 866-700-2168 for assistance or refer to the "Other Payor" listing, which may include MPN Program Contact and/or the online Provider search websites for clients that utilize the Anthem network for their MPN.
- **Services obtained outside of the MPN may not be paid.** If you have not been selected to participate in the specific MPN treating the patient, your services may be considered outside the MPN and not be reimbursable. Contact the claims adjuster for authorization for any medical care outside of the MPN.
- **The injured worker may select a physician of his or her choice from within the MPN**, at any point in time after the initial medical evaluation with an MPN physician. Selection by the injured worker of a treating physician and any subsequent physicians shall be based on the physician's specialty or recognized expertise in treating the particular injury or condition in question.

  If a chiropractor is selected as a treating physician, the chiropractor may act as a treating physician only until the 24-visit cap is met unless otherwise authorized by the employer or insurer, after which the injured worker must select another treating physician in the MPN who is not a

chiropractor, and if the employee fails to do so, then the insurer or employer may assign another treating physician who is not a chiropractor pursuant to C.C.R. §9767.6.

- **If the injured worker disputes the diagnosis or treatment plan of the MPN Provider**, there is a second- and third-opinion process established by the Administrative Director of the DWC included as part of the MPN policies and procedures.
- **Maintain medical records, records of accounts and payments, reports, and other documents** that were necessary for the delivery of the medical services. These must be maintained for at least five years from the date of delivery of the medical service, and the obligation to maintain such records does not end on termination of the Agreement with the Prudent Buyer Network. All such records, including records pertaining to the cost to the health care practitioner for delivery of the medical care and the payments received by the health care practitioner for such care, will be made available to the MPN, on request, during regular business hours.
- **Requests for Authorization (RFA) should be submitted** to the Claims Administrator or Utilization Review Organization using the DWC Form RFA, following the treatment guidelines found in the Medical Treatment Utilization Schedule (MTUS). The DWC Form RFA must include as an attachment documentation substantiating the need for the requested treatment. Services provided without proper authorization pursuant to CA Labor Code 4610 may not be reimbursable.
- **While a claim is under investigation** the claims administrator will ensure payment for authorized medical services rendered, persuant to CA Labor Code 5402 (c), until such time as a denial of the claim is made by the claims administrator.
- **Submit medical bills within 60 days** following delivery of health care services to the appropriate Workers' Compensation administrator.
- **CA Labor Code 3751 (b) prohibits any surcharges or other billings** for Workers' Compensation health care services or balance billing the injured worker.
- **Demonstrate participation in educational activities** for occupational medicine and Workers' Compensation, including, but not limited to:
  1. Regulatory requirements for primary treating physicians
  2. Workplace health and safety issues
  3. Vocational rehabilitation

Online Provider Directory

For Prudent Buyer Network PPO Services, the Workers' Compensation online Provider directory is available by visiting www.anthemwc.com/find_a_doctor.asp and selecting "California." Assistance is also available by calling 866-700-2168. This online Provider directory will identify Providers who treat work-related illness or injuries.

Physician Referrals Within the Anthem Workers' Compensation Network or Other Payor MPN

As required by your Anthem Agreement, referrals to specialist or our other contracted participating Providers, hospitals, ambulatory surgery centers, ancillary networks and Behavioral Health networks must be within the Anthem Workers' Compensation Network or for clients that have an MPN, within the client's MPN. To ensure that you utilize the correct online directory please refer to the list of Other Payors for Workers' Compensation Network Leasing, which is available on the Anthem secure portal for ProviderAccess® site. Click on link for "Network Leasing Arrangements" to download the list and search for Payors that have a specific directory web address. For instructions on how to log on to ProviderAccess, see below:

- You must have a ProviderAccess account and PIN for secure access. If you do not have an account, you may register at ProviderAccess®.
- Only authorized users can access the website. You, the Provider, are given rights to assign user levels of access and identifications to your own staff. This is handled by the individual on your staff who has administrator rights for management of the ProviderAccess account.
- ProviderAccess is available 24 hours a day, 7 days a week, except during scheduled maintenance and national holidays.
- ProviderAccess offers printer-friendly format on all information screens.
- ProviderAccess Login and Technical Support:
  - For password related questions, system outages, error messages, and/or technical difficulties, please contact us at 866-755-2680, Monday through Friday, 5 a.m. to 5 p.m. PST.

Physician Referrals – Regulatory Compliance

CA Labor Code 139.3 states it is unlawful for a physician to refer a person for medical services as defined in sections 139.3 and 139.31, whether for treatment or medical-legal purposes, if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

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 www.dir.ca.gov/t8/9785.html

Guide for the Treating Physician

The DWC has established MPN regulations for injured workers to access care and guidelines to improve the quality of medical care for occupational injuries. A "Guide for the Treating Physician" in the Workers' Compensation System has been written and is posted on our website in the California Resources and Forms section for Providers.

Go to https://www.anthemwc.com/home_provider.asp and select California from the

"Select a Service Area" drop down menu under **Forms and Resources**. This guide outlines some of the very important duties and requirements of the treating physician as outlined in the California Labor Code. We would encourage you to read this guide and become familiar with the California state mandated requirements. Below we have outlined some of the reporting requirements.

California Code of Regulations §9785 Reporting Duties of the Primary Treating Physician

Click the link, www.dir.ca.gov/t8/9785.html to view the regulation. Within five (5) calendar days of initial visit, a "Doctor's First Report of Injury or Illness (form 5021)" must be completed and sent to the Claims Administrator. This must be submitted by each new primary treating physician. The form must be completed including the information regarding frequency and duration of planned treatments, consultations, referrals, surgery or hospitalization, and the type, frequency and duration of planned physical medicine treatment on the reverse side of the form. These forms are available at www.dir.ca.gov/dwc/forms.html

Additional reports (PR2) shall be submitted within twenty (20) days if the injured workers' condition undergoes a previously unexpected significant change, there is any significant change to the treatment plan reported previously, the injured worker is felt to be capable of returning to modified or regular work, the injured worker's condition requires him/her to leave work or requires changes in the work restrictions, the injured worker is released from medical care, or the injured worker is felt to be unable eventually to return to his/her usual occupation or the occupation in which the injured worker was engaged in at the time of the injury. When continuing medical treatment is provided, the PR2 shall be submitted no later than forty-five (45) days from the previous report but no later than twenty (20) days of the examination. These forms are available at www.dir.ca.gov/dwc/forms.html

If a narrative report is submitted, it should be clearly titled "Primary Treating Physician's Progress Report" and should contain the same information as the PR2. A narrative report must have the mandated declaration below the signature of: "I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3"

When the physician determines that the injured worker's condition is permanent and stationary [maximum medical improvement (MMI)], the physician shall report this within twenty (20) days from the date of examination any findings concerning the extent of permanent impairment and limitations and any need for continuing and/or future care on the "Primacy Treating Physician's Permanent and Stationary Report," which is Form PR3 or PR4. These are available at www.dir.ca.gov/dwc/forms.html

Permanent disability evaluation should be performed in accordance with the AMA Guides to the Evaluation on Permanent Impairment, 5th edition. The physician is also able to refer the injured worker to another MPN physician for this report and if this is necessary, it should be discussed with the Claims Examiner.

Other Responsibilities of the Primary Treating Physician

Availability

- For non-emergency services, the primary treating physician must see the injured worker within three (3) business days of the request.
- For specialty services, the specialist must see the injured worker within twenty (20) business days of the request.

Causation

- When requested, the treating physician must address causation issues. Causation is the medical likelihood that the diagnosis is causally related to the mechanism of injury alleged to have occurred.

Medication issues

- Under the California Labor Code, the physician is to prescribe generic drugs unless clearly documented for reason that brand drugs are required and comply with a Pharmacy Benefit Program.
- The physician is obligated to use the Pharmacy Benefit Program when made available to the injured worker and may not dispense medication from the office.
- The physician is to prescribe medication in accordance with MTUS Chronic Pain Treatment Guidelines, which are available at: www.dir.ca.gov/dwc/DWCPropRegs/MTUS_Regulations/MTUS_ChronicPainMedicalTreatmentGuidelines.pdf

Rules for Calculating Permanent Disability

The calculation of permanent disability is to be conducted in accordance with the *American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment, 5th Edition*. Information about this guide can be obtained by accessing www.ama-assn.org.

If you feel you are unable to write the permanent and stationary report, contact the claims examiner to refer the patient to another physician to prepare a report utilizing these guides.

Network Leasing

Anthem Workers' Compensation Payors, Other Payors (PPO and MPN)

We are providing a listing of our Other Payors (Workers' Compensation Insurance Carriers, Self Insured's including Self-Insurer's Security Fund, a group of self-insured employers pursuant to CA Labor Code section 3700(b) and as defined by Title 8, C.C.R. §5402, a joint powers authority, the state and Third Party Administrators or Entities Providing Physician Network Services) who are leasing the network access to our Anthem Workers' Compensation Network, which is comprised of our Prudent Buyer Network and may be used both as PPO and MPN.

To access a list of participating payors, go online to the Anthem Blue Cross website anthem.com/ca > Providers > ProviderAccess® and log in to obtain access.

"Opting Out" of Treating Work-related Injuries and/or a specific MPN

Opting Out of an Individual MPN

As a medical Provider you have the right to affirmatively elect to be a Member of any MPN that includes you as participating Provider pursuant to CCR §9767.5.1. Anthem Workers' Compensation maintains an online Provider Affirmation Portal where you can view a list of the MPNs that access Anthem's network of Providers, for which you are a participating Provider. If the MPN Applicant (insurance carrier, self-insured employer, Entities Providing Physician Network Services) has subscribed to the MPN Provider Affirmation

Portal and you have been selected to participate in their MPN, you will find their MPN(s) listed to opt out of. If you have opted out of an MPN and wish to rejoin, you may "Request Reinstatement" in the portal which will go to the MPN for review and consideration.

If you do not see an MPN listed, the MPN is either not an Anthem customer, has not subscribed to this portal service, or has not selected you to participate in their MPN. Please contact the MPN Contact for the MPN directly to inquire or affirm MPN participation.

To access the Anthem Workers' Compensation Provider Affirmation Portal for Medical Provider Networks, go online to the Anthem Blue Cross website anthem.com/ca > Providers > ProviderAccess® and log in. If you do not have your login information, use the "Forgot User Name" or "Forgot User Password" options on the page. Once in, look for the link to the Provider Affirmation Portal for Workers' Compensation MPNs.

Opting Out of ALL Anthem Workers' Compensation

Anthem Workers' Compensation does recognize that some participating practitioners do not provide Workers' Compensation services. For those participating practitioners who do not provide such services, notification must be sent to Anthem Workers' Compensation MPN Services. After appropriate notification is received, and reviewed, participating practitioners will be removed from the Workers' Compensation online Provider Finder as appropriate. If you do not treat Workers' Compensation patients and wish to opt out, please contact us at 866-700-2168. You may also opt out of all Workers' Compensation in the Provider Affirmation Portal described in the section above.

Notification Requirements

Notification must be in writing, signed and dated by the practitioner and sent to:

Anthem Workers' Compensation
MPN Services
P.O Box 70022
Anaheim, CA 95825-0022

Fax: 855-325-1575

Network Pricing Questions

For questions regarding payment per your contract rate, please contact AWC at 866-700-2168.

Note: If you have a question regarding how the California Official Medical Fee Schedule was applied, please contact the customer service number on the EOR.

Practice Focus: Workers' Compensation Services Only

Participating Providers who only treat Workers' Compensation services injuries or illness may request an *Anthem Blue Cross Occupational Medicine Network Participating Agreement* or *Mental Health Practitioner Agreement* depending upon your specialty (medical vs. behavioral health). Participating practitioners may send written notice to Anthem Workers' Compensation MPN Services. See the *Notification Requirements* information.

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Introduction

The following summaries describe a broad variety of Anthem Blue Cross 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.

Participating practitioners must verify benefits and eligibility to determine if a Covered Individual accesses any of the Anthem Blue Cross Provider Networks. The Covered Individual's ID card is intended to identify the Covered Individual's medical plan and may not always identify the behavioral health program. Some plans may or may not utilize the Anthem Blue Cross Behavioral Health Network. Always call the Customer Service Unit toll-free telephone number on the Covered Individual's ID card for eligibility, benefits and copayment information.

Not all plans require Case Management (CM) and Utilization Review. Always call the Customer Service Unit using the telephone number on the back of the Covered Individual's ID card.

Note: This section is not an exhaustive list or a description of all products offered by Anthem Blue Cross, because new products may be created throughout the year. Anthem Blue Cross offers these product summaries for clarity purposes. Participating practitioners should also review the *Appendix A Affiliates List* and *Appendix B Other Payors List Network Leasing Arrangements* section in this Manual to become familiar with the Anthem Blue Cross Affiliates and Other Payors.

Access for Infants and Mothers (AIM)

The Access for Infants and Mothers (AIM) program is an outgrowth of California's Managed Risk Medical Insurance Program (MRMIP). This program provides coverage to individuals not covered by private insurance. The AIM program is administered by MRMIP's five-member board, and establishes a complete benefit package of inpatient and outpatient services for program enrollees. Pregnant women participate in the cost of their health care services through a low-cost Subscriber contribution. Because the funds for the AIM program are generated by cigarette and tobacco tax revenues (AB 99), the program places emphasis on health education, including education on the harmful effects of using tobacco during pregnancy.

Anthem Blue Cross Life and Health Insurance Company

Anthem Blue Cross Life and Health Insurance Company offers PPO and Fee for Service (FFS) plans utilizing the Prudent Buyer Network. The Anthem Blue Cross Life and Health Insurance Company 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 (HRAs) or plans, which work with Health Savings Accounts (HSAs).

Lumenos® HSA

Whether through employer contributions or a Covered Individual's own pretax money, the Lumenos HSA will help pay for future health expenses and build savings for retirement.

Lumenos HRA

An employer allocates funds to a Covered Individual's HRA without spending anything out of pocket first. Unused funds can be used to help reduce future out-of-pocket costs.

Lumenos HIA Plus

Covered Individuals use the allocation to their HIA Plus without spending anything out of pocket first. Covered Individuals 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, Covered Individuals can earn extra dollars through the Healthy Rewards program for a HIA that helps offset future out-of-pocket costs for medical care and prescriptions.

BC PPO (non-California resident)

The BC PPO plans are offered to California-based companies who have employees outside of California. The BC PPO plans are preferred Provider plans, which utilize the Provider Networks of other Blue Cross and/or Blue Shield plans (these are called Host Blue Cross Blue Shield Plans).

Behavioral Health Program

Behavioral health is an integrated part of the Anthem Blue Cross medical product line. Covered Individuals 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 Blue Cross. Anthem Blue Cross is your sole contact for claims payment, adjustments and issue resolution.

Anthem Dual Advantage (HMO SNP)

Anthem Dual Advantage (HMO SNP) is a Medicare Advantage insurance plan for beneficiaries with both Medicare and Medicaid. Serving select counties in California, these plans provide benefits for Medicare Covered Services and prescription drugs. Additional services such as routine dental, hearing, vision and transportation are included with the coverage.

Anthem Medicare Preferred PPO

Anthem Medicare Preferred PPO from Anthem Blue Cross Life and Health Insurance Company is a Medicare Advantage Preferred Provider Organization (PPO) plan available to Medicare beneficiaries within select counties in California. Prescription drug coverage is included with the Anthem Medicare Preferred PPO plan.

Anthem Select Advantage (HMO)

Anthem Select Advantage is an HMO-based Medicare Advantage plan for the Medicare-eligible population that features a focused network of high performing doctors. With this plan, medical care, emergency care and out-of-area urgent care services are provided or coordinated through the PCP and/or medical group of the Covered Individual's choosing.

Blue Cross HMO

Blue Cross HMO is a health maintenance organization (HMO) designed to support Covered Individuals' efforts to stay well, and provide them convenient access to the most appropriate and cost-effective quality health care. Each Covered Individual enrolled in Blue Cross HMO chooses a primary care physician (PCP) or a primary medical group (PMG) who is responsible for providing or coordinating health care services for that Covered Individual.

Blue Cross POS

Blue Cross POS is a point-of-service (POS) plan that is primarily an HMO plan that provides Covered Individuals with the option of getting benefits from their Blue Cross HMO PCP/PMG or selecting to get services from a Blue Cross PPO (Prudent Buyer Plan) Network Provider or an out-of-network health care professional. Under this plan, preventive care services are provided only under the Blue Cross HMO Plan.

Blue Cross PPO (Prudent Buyer Plan®)

The Blue Cross PPO (Prudent Buyer Plan) is a Preferred Provider Organization (PPO) that includes family practice physicians, pediatricians, gynecologists, a wide variety of specialists and hospital-based physicians. The Blue Cross PPO offers Covered Individuals the ability to choose more than one physician from the network, depending on the services required. Covered Individuals may self-refer to any physician in the network. Benefit plans are designed with financial incentives for Covered Individuals to use health care professionals in the Prudent Buyer Plan Network.

Blue Cross Preferred HMO (HMO POS)

Blue Cross Preferred HMO (HMO POS) combines the benefits of Blue Cross HMO with the flexibility of the Blue Cross PPO, providing Covered Individuals with access to both HMO and PPO Networks. Covered Individuals can receive care from their selected Blue Cross HMO PMG/independent practice association (IPA), or they can choose to see a PPO health care professional, without a referral, for a limited number of outpatient and professional services that are separate from the 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. Physicians and physician groups who participate in this network were selected based on clinically efficient health care practices, accessibility and quality. The Select PPO Network is a subset of the physicians who are also participating Providers in the Prudent Buyer PPO Plan Network. Prudent Buyer PPO Plan Network physicians who are not in the Select PPO Network are considered out of network for Select PPO Covered Individuals.

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.

Select PPO is currently not offered nor available in the following counties: Alameda, Marin, Placer and Solano.

Blue Cross Medicare Supplement Open Plans (Currently Sold): A, F and N

Anthem Blue Cross offers a variety of Medicare Supplement plans that help cover the “gaps” between what Medicare pays and what it does not pay. Blue Cross Medicare Supplement plans provide Covered Individuals with the freedom to use the doctor and hospital of their choice. Plans are available with different levels of coverage, benefits and monthly costs to fit the individual needs of seniors, benefits for foreign travel emergencies and coverage for skilled nursing benefits.

Blue Cross Medicare Supplement Closed Plans

Anthem Blue Cross has several Medicare Supplement plans that are closed to new enrollment. Covered Individuals are allowed to keep their Medicare Supplement policy even after it closes to new enrollment. Covered Individuals may present for services with an ID card that reference Pre-standardized Plans (Medicare Supplement plans offered prior to introduction of the alpha Standardized Plans), 1992 Standardized Plans (Plan A – L) or closed Modernized Plans (1992 updated in 2010). Some of the closed plans do provide prescription drug coverage. Example of closed Medicare Supplement Plans include: Blue Cross Senior Classic Plans C, F, I, J; SmartChoice Preferred and Plus; Claim Free Companion Care; Medicare Select II, UltraCare Plus 10K and 25K; Claim Free Prudent Buyer; and Platinum w/Rx to name a few. If there are questions regarding Covered Services, the Covered Individual should call Customer Service number on their ID card.

Some of the closed plans may include the *Blue Cross Senior Advantage Care* Plan. It is a rider that covers home health and nursing home care benefits including home support and residential Facility care services.

Blue Cross Senior Secure℠

Blue Cross Senior Secure is an HMO-based Medicare Advantage plan for the Medicare-eligible population. With this plan, medical care, emergency care and out-of-area urgent care services are provided or coordinated through the PCP and/or medical group of the Covered Individual’s choosing.

CareAdvocate PPO

CareAdvocate PPO, an Anthem Blue Cross Life and Health Insurance Company product, offers the freedom of PPO coverage while integrating effective care management and supportive health resources.

Several benefit designs are currently available that differ in deductible, copayments and coinsurance amounts. Each design offers office visit copayments for physician visits and coinsurance for remaining services. Benefits such as out-of-pocket and lifetime maximums are similar to other Blue Cross PPO products.

CareAdvocate plans have financial incentives for Covered Individuals to contact Anthem Blue Cross prior to receiving specialty services (there are higher copayments for failure to contact Anthem Blue Cross prior to obtaining care). There are different levels of benefits within each plan for services that require pre-notification. The benefits for specialty care are based on the Provider type and whether pre-notification was given:

- PPO Providers with notification/highest benefit level
- PPO Providers without notification/second-highest benefit level
- Non-PPO Providers/lowest benefit level

Prior to receiving services of a specialty care Provider or service, enrollees must contact Anthem Blue Cross in order to receive a greater benefit. Specialty care services include visits to specialists, surgery, Ambulatory Surgical Centers, SNF, HHA, hospice, MRIs, CT scans, DME, radiation therapy, HIT, all non-emergency hospitalization (inpatient or outpatient) and most services not performed by a PCP.

Pre-notification is not required for primary or routine care received at a PCP's office in the PPO Network. PCPs are pediatricians, internists, general and family practitioners, OB/GYNs, and nurse practitioners. In addition, pre-notification is not required for most lab and X-ray services, however, certain services such as CT scan and MRI are exceptions.

HealthyCheck℠ Centers

HealthyCheck centers are located at certain participating hospitals and medical groups throughout California that offer annual preventive screenings to PPO Covered Individuals ages seven through adult for a designated copayment. Services performed include, but are not limited to, a health risk appraisal and physical assessment; various lab tests, including cholesterol and glucose; skin cancer education; and immunizations, as needed. Additional services are available for additional copayments.

Healthy Families

Healthy Families is a California state-sponsored insurance program offering low-cost health, dental and vision coverage to children of low-income, working families. Depending on the county in which the enrollee resides, Anthem Blue Cross offers an HMO product or an Exclusive Provider Organization (EPO) product a separate and distinct Healthy Families contract agreement. Anthem Blue Cross terminated state contracts to cover Covered Individuals enrolled in the Health Family Program in Alameda, Contra Costa, Fresno, Monterey, Sacramento, San Francisco, San Mateo, Santa Barbara, Solano, Stanislaus and Yolo Counties.

Note: The Anthem Blue Cross Healthy Families Program is not a Medicaid Program. Anthem Blue Cross administers the behavioral health and substance abuse program available under the Healthy Families Program. Participating practitioners in the Anthem Blue Cross Behavioral Health Network may be contacted by Healthy Families Covered Individuals for treatment.

The following provisions apply:

- All outpatient and inpatient services require preauthorization
- The Anthem Blue Cross Behavioral Health Network Payment Schedule and billing processes apply
- Healthy Families is a covered product as indicated in your Anthem Blue Cross Participating Behavioral Health Practitioner Agreement and is served by the Anthem Blue Cross Behavioral Health Network

Coverage, CM/Utilization Review and reimbursement procedures will be similar to those in the PPO products, with the exception of outpatient services for Serious Emotional Disturbance (SED). Outpatient management of SED services must be referred to and provided by the Mental Health Department in the patient's county of residence. Call the Customer Service Unit toll-free telephone number on the Covered Individual's ID card for eligibility, benefits and copayment information.

Managed Care Services

The Managed Care Services product is available from Anthem Blue Cross Life and Health Insurance Company to group accounts that are self-funded. Self-funded employers are provided assistance with benefit package design, claims processing, administration, Utilization Management (UM) and management reports. Employers can access the PPO Network and design health benefit plans to meet their own needs. ID cards may display the employer's logo.

Prescription Drug Benefits

If a medical plan includes Prescription Drug Benefits, there is a complete package of services, including prescription drug UM, Covered Individual 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 Covered Individuals.

Special Offers

Special Offers is a program that provides Anthem Blue Cross Covered Individuals information about a wide range of products and services, available at a discount, to help them meet their individual health, fitness and wellness goals. Covered Individuals 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 Blue Cross website, anthem.com/ca, click on "Special Offers" 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 "Special Offers" are not covered benefits under the Covered Individual's health plan.

! Vendors and offers are subject to change without prior notice. Anthem does not endorse and is not responsible for the products, services or information provided by the vendors. Services and supplies accessed through this program are NOT a part of your health coverage. Please refer to your schedule of benefits for coverage details. Information is being provided for educational purposes only and should not be considered medical advice or treatment. Please consult your doctor for advice about changes that could affect your health or lifestyle.

Specialty Drug Program

Anthem Blue Cross' Specialty Drug Program is designed to more effectively manage and monitor the distribution of specialty drugs. Specialty drugs are defined as high-cost, injectable, infused, oral or inhaled drugs that generally require close supervision and monitoring of the patient's drug therapy. These drugs often require special handling, such as temperature controlled packaging and overnight delivery, and are often unavailable at retail stores.

Specialty medications are used to treat conditions such as multiple sclerosis, cancer, hepatitis c, Gaucher's disease, HIV, and certain forms of rheumatoid arthritis. You may obtain a list of medications from anthem.com/ca. These medications can cost as much as $200,000 per year and are costly to ship, store and administer.

Our Specialty Pharmacy Program vendor offers a complete support program including a team of nurses, pharmacists and care coordinators to help Covered Individuals taking specialty medications achieve the best possible outcomes from their treatments in collaboration with the prescribing physician. For more detailed information regarding Specialty Pharmacy program please reference Specialty Drug Fulfillment located in the *Pharmacy Program and Guidelines* section in this Manual.

Workers' Compensation

Anthem Workers' Compensation (AWC) is a business unit marketed under Anthem Blue Cross Life and Health Insurance Company, an affiliate of Anthem Blue Cross. AWC focuses on integrating group health and Workers' Compensation. This approach allows employees and Covered Individuals to use the, to the PPO (includes network as both a PPO and as a Medical Provider Network) for insurance companies, self-insured employers, and Entities Providing Physician Network Services in California. This includes both medical Provider and behavioral health Providers as listed on the Workers' Compensation online Provider Finder. For more information about AWC, refer to the *Workers' Compensation* section in this Manual.

Glossary

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Purpose and Introduction

We appreciate your participation in Anthem Blue Cross Network. Anthem Blue Cross is committed to working with our Providers and Covered Individuals to provide a high level of satisfaction in delivering quality care. The *Anthem Blue Cross Professional Provider Manual* (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 Blue Cross shall supersede any terms and definitions offered in this *Glossary.* As Anthem Blue Cross 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 represent various products, contracted Providers, organizations, and specialized concepts and services that all relate to managed care. To help you understand the meaning of this specialized terminology, the following is a glossary of current terms:

ABA. Refer to the definition within this section *Applied Behavior Analysis*.

Access for Infants and Mothers (AIM). A program for expectant women and their babies in which Anthem Blue Cross contracts with the state of California to provide prenatal and preventive care. This program increases access to maternity, delivery, and infant care services for pregnant women and infants who are not covered by private insurance, and not eligible for state programs, such as Medicaid. Pregnant women participate in the cost of their health care services through a low-cost Subscriber contribution.

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.

Acupuncture. Anthem Blue Cross contracts with American Specialty Health Networks (ASHN) to access their network of participating acupuncture health care professionals.

Acute Rehabilitation. Medical services that are provided on an inpatient basis at a licensed rehabilitation Facility and require intensive nursing services, as well as occupational, physical and speech therapy.

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 Blue Cross. Refer to *Appendix A – Affiliates List*.

AIM Specialty Health (AIM→). As of March 2012, American Imaging Management (AIM) is now AIM Specialty Health, a leading specialty benefit management company.

Alternate Birth Center. This network is made up of birth Facilities that provide a homelike atmosphere for the mother and infant.

Ambulance. This network is made up of both ground and air ambulance health care Providers that transport the Anthem Blue Cross Covered Individual 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 **only** for scheduled services. Covered Individuals 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.

American Imaging Management (AIM). As of March 2012, American Imaging Management (AIM) is now AIM Specialty Health. See *AIM Specialty Health (AIM)*.

Ancillary Networks. Anthem Blue Cross has a series of statewide specialty networks. These networks encompass a wide range of medical, therapeutic and behavioral health services that expand or, in some cases, provide new alternatives for treatment available from Anthem Blue Cross. Ancillary networks are available for all products, including Blue Cross PPO (Prudent Buyer Plan) and Blue Cross Select PPO.

Anthem Blue Cross. A health care service plan regulated by the California Department of Managed Health Care (DMHC).

Anthem Blue Cross EPO (Prudent Buyer Exclusive). Plan in which benefits are covered and paid by Anthem Blue Cross through exclusive use of Prudent Buyer Plan Network health care professionals. Exceptions are made only for authorized referrals from the Anthem Blue Cross Review Center, and for emergency and urgent medical care.

Anthem Blue Cross Life and Health Insurance Company. An insurance company regulated by the California Department of Insurance (CDI).

Anthem Blue Cross Medicare Advantage Preferred. A PPO-based Medicare Advantage (MA) Plan for Medicare beneficiaries.

Anthem Blue Cross Specialty Drug Pre-service Medical Review Program. Reviews for the Medical Necessity of specialty injectable or infusible medications that are covered under the Member's medical benefit.

Applied Behavior Analysis. 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 (EDI) 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 Provider Manual that refers to the review, approval and/or approval process inherent in the Anthem Blue Cross Medical Management Program. This includes pre-service, care coordination and post-service reviews. Common synonyms include "certification" and "approval."

Availity Web Portal (Availity). Availity optimizes the flow of information between health care Providers, health plans and other health care stakeholder through a secure collaborative Internet-based exchange. It creates greater value by streamlining administrative workflow through a single online connection to multiple health plans, while improving the patient experience.

Behavioral Health Facility. Any general acute hospital, psychiatric hospital, psychiatric health Facility, chemical dependence recovery hospital, residential treatment center, day treatment Facility, or other outpatient setting that provides behavioral health services.

Behavioral Health Care. The provision of mental health and substance abuse services.

Behavioral Health Provider. Behavioral health care practitioners, including psychiatrists, psychologists, psychiatric mental health nurses, marriage and family therapists, and licensed clinical social workers.

Behavioral Health Services. Services for the evaluation and treatment of mental disorders and substance abuse conditions.

Benefit Agreement. The written agreement entered into between Anthem Blue Cross and a group or individual, pursuant to which Anthem Blue Cross indemnifies health care expenses, provides or administers health care benefits, or otherwise pays or arranges for the payment of benefits for health care services; and includes, but is not limited to: Blue Cross PPO (Prudent Buyer), Blue Cross HMO, Blue Cross POS (Blue Cross Plus), Blue Cross Senior Secure and other Anthem Blue Cross plans. Benefit Agreement(s) also means the arrangement(s) established by Anthem Blue Cross, or by persons or entities utilizing the managed care network pursuant to an agreement with Anthem Blue Cross. Anthem Blue Cross may contract with other payors that wish to use the services of the managed care network, and incorporate the terms and conditions of this agreement.

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. Synonyms may include covered benefits.

Benefit Substitution. The use of an existing covered benefit, including any terms, conditions or limitations associated with the covered benefit, to provide a covered benefit to the Covered Individual when one of their covered benefits has been exhausted.

Blue Cross Blue Shield Association (The Association). The Blue Cross and Blue Shield Association is a national federation of independent, community-based and locally operated Blue Cross® and Blue Shield® companies. The Association owns and manages the Blue Cross and Blue Shield trademarks and names in more than 170 countries and territories around the world. The Association grants licenses to independent companies to use the trademarks and names in exclusive geographic areas. The Association also operates several business initiatives in support of the Blue Cross and Blue Shield companies and represents the Blue System in national forums. In this role as a national association, BCBSA is responsible for advancing Blue Cross and Blue Shield interests in legislative and regulatory initiatives in Washington, D.C., as well as coordinating legislative, regulatory and political strategy for the Blue System.

Blue Cross Medicare Advantage Preferred. A PPO-based Medicare Advantage (MA) Plan for Medicare beneficiaries.

Blue Cross HMO Participating Provider. A physician, medical group or independent practice associate (IPA) that has a Blue Cross HMO *Medical Services Agreement* (or other *Blue Cross HMO Participating Physician Agreement*) with Anthem Blue Cross to provide medical services to Anthem Blue Cross HMO plan Covered Individuals.

Blue Cross HMO. Anthem Blue Cross' health maintenance organization (HMO). The Covered Individual chooses a primary care physician (PCP) who coordinates a comprehensive range of health care services.

While there is no calendar-year deductible, there may be a copayment for office visits to the PCP and specialists. The copayments may vary between $0 and $40, depending on the Covered Individual's plan. Some plans have a copayment that is a percentage of covered billed charges. National coverage is provided through HMO USA.

Blue Cross HMO Plus. Enhances any CaliforniaCare plan by extending choice. Anthem Blue Cross HMO Plus Covered Individuals still receive the majority of health care services from their HMO plan. However, they may obtain certain outpatient services from Blue Cross PPO (Prudent Buyer Plan) health care Providers. These services include:

1. Outpatient hospital care
2. Ambulatory surgical centers
3. Surgeon, assistant surgeon, anesthesiologist and anesthetist services
4. Physician office visits
5. Eye and hearing examinations
6. X-ray and lab
7. Outpatient physical therapy, physical medicine, speech therapy and occupational therapy

Covered Individuals may use Blue Cross HMO Plus to obtain services from a Blue Cross PPO (Prudent Buyer Plan) health care Provider for a limited dollar amount per calendar year. Services received from non-Blue Cross PPO (Prudent Buyer Plan) health care Providers are not covered.

The Blue Cross HMO Plus benefits are separate from Blue Cross HMO benefits. As such, Anthem Blue Cross HMO Plus benefits are subject to a deductible, copayments and an annual benefit maximum.

Blue Cross POS (Blue Cross Plus). A point-of-service (POS) product that allows the Covered Individual the option of using a Blue Cross HMO PCP, a Blue Cross PPO health care professional (Prudent Buyer) or an out-of-network health care professional (non-PPO health care professional) for certain services.

1. **HMO.** This includes all in-network services provided, referred or authorized by the Covered Individual's participating medical group/independent practice association (PMG/IPA). Services received through the HMO provide the highest level of coverage available, as determined by the Covered Individual's group contract.
2. **Self-Referral, Preferred Provider Organization (PPO).** These services are covered at a reduced benefit because care is rendered by a Blue Cross PPO (Prudent Buyer Plan) participating health care professional who may not be in the Covered Individual's selected PMG/IPA.

   Blue Cross PPO health care professionals should not deny services when a Blue Cross POS Covered Individual self-refers to the health care professional's office. Self-referral services provided to a Blue Cross POS Covered Individual are reimbursed according to the contracted Blue Cross PPO rate structure and the Covered Individual's group contract. Blue Cross PPO health care professionals should submit all Blue Cross POS claims to the address on the Covered Individual's ID card.
3. **Self-referral services rendered by a non-Blue Cross PPO (Prudent Buyer Plan) health care professional.** These services are covered with an even greater reduction in benefits because Anthem Blue Cross has no contractual rates in place with these health care professionals. Covered Individuals may choose any licensed health care professional under this level of coverage.

Blue Cross Select PPO. The Select PPO Network is a statewide PPO Network made up of primary and specialty care physicians and physician groups that also participate in the Prudent Buyer PPO Network. The Select PPO Network is a subset of the physicians who are also participating Providers in the Prudent Buyer PPO Plan Network. Physicians and physician groups who participate in this network were selected based on clinically efficient health care practices, and accessibility Prudent Buyer PPO Plan Network physicians who are not in the Select PPO Network are considered out of network for Select PPO Covered Individuals. Most, but not all, hospitals and ancillary Providers participate in the Select PPO Network. *Appendix D* provides a list of the Hospitals and ancillary Providers that do not participate in the Select PPO Network.

Blue Cross Senior Secure℠. An HMO-based Medicare Advantage plan for Medicare beneficiaries. It includes a self-referral benefit to Blue Cross PPO (Prudent Buyer Plan) physicians called Choices Plus. Choices Plus allows the Covered Individual up to three office visits per year, with a $30 copayment for each visit. This program covers the physician office visit only; any other services, such as laboratory, radiology or surgery, must be authorized by the Covered Individual's PCP or medical group. For more information on Blue Cross Senior Secure, see the *Directory of Services* section of this Manual.

Blue Cross Senior Select℠. Blue Cross Senior Select℠; Select Plus℠; Senior Classic℠ C, F, I and J Plans; SmartChoice℠; Smart Choice Plus℠, and AdvantageCare℠ are Medicare Supplement plans.

BlueCard® Program. The mechanism by which Anthem Blue Cross, as the host plan, arranges for the

payment of care rendered to Blue Cross and/or Blue Shield Covered Individuals of out-of-state plans by the health care professional. BlueCard program Covered Individuals include those who hold the applicable Blue Cross and/or Blue Shield Plan ID card, as well as those who hold an ID card with the Blue Cross and/or Blue Shield name and logo, but no plan name or state.

Care Coordination. A function performed by Anthem Blue Cross to review and determine whether medical services provided, or to be provided, are medically necessary. Also includes discharge and transition of care planning. Synonyms include: "Utilization Review."

Case Management (CM). A collaborative process of Covered Individual advocacy that evaluates, develops, implements, and coordinates options, resources and services. It includes working one-on-one with Covered Individuals, their families and other Covered Individuals of the interdisciplinary care team, using behavioral change science to promote engagement. Covered Individuals 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.

Centers of Medical Excellence (CME) Network – Providers. The network of health care Providers that entered into contracts with Anthem Blue Cross, or one or more of its affiliates, to provide transplant or other designated specialty services. For a list of network health care professionals, refer to the *Blue Cross PPO (Prudent Buyer Plan) Directory*.

Centers of Medical Excellence (CME) – Facilities. Anthem Blue Cross 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 Blue Cross 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

Chemical Dependency Disorders. See *Substance Abuse Disorders*.

Chiropractic Services. Practitioners who treat neuromusculoskeletal disorders, using manipulation and therapy for spinal and joint adjustments. Anthem Blue Cross 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 claim form maintained by CMS, recommended by Anthem Blue Cross 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 Covered Individual pays each year before the insurance plan pays 100 percent of allowable charges for Covered Services. Coinsurance amounts differ with each plan.

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 Covered Individual.

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 Covered Individual 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 Covered Individual 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.

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 Individual(s). Subscribers or enrolled dependents covered by an Anthem Blue Cross *Agreement.* Also referenced as a “patient” or “Member.”

Covered Persons. Covered Individuals, enrollees, employees, dependents and other beneficiaries who are covered by an affiliate’s Benefit Agreement or by another payor.

Covered Services. Medically necessary services or supplies for which benefits are offered in the Covered Individual’s Evidence of Coverage (EOC).

CPT Code. Billing code used on *CMS-1500* forms for identifying the service(s) rendered to Covered

Individuals. 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.

Custodial Care. Care provided primarily to assist the Covered Individual 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.

Deductible. The amount of charges some Covered Individuals must pay for any covered expense before selected benefits are available under their plan. The Covered Individual'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.

EDI (Electronic Data Interchange). Computer-to-computer transfer of transactions and information. Currently, Anthem Blue Cross Behavioral Health and EAP practitioners may use EDI for submitting claims, receiving ERAs, and submitting benefits and eligibility inquiries.

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 condition manifesting itself by acute symptoms of sufficient severity, which the Covered Individual reasonably perceives could result in the Covered Individual's actions causing harm to the Covered Individual or placing others in danger, unless immediate transport, supervision, or intervention by a public safety representative or licensed medical professional is obtained.

**Non-life Threatening Emergency is defined as a situation where a person is experiencing acute distress and/or symptoms and appears to require attention.*

Experimental/Investigational Procedures. Services that are not recognized under generally accepted medical standards as safe and effective for treating a particular condition.

Extension of Benefits. Extended benefits that may be available to Covered Individuals who are totally disabled on the termination date of their Benefit Agreement. Extended benefits are defined in the Covered Individual's Benefit Agreement.

Facility Services. Those acute care inpatient, residential, rehabilitation and hospital day treatment outpatient services, which are covered by a Benefit Agreement providing coverage for mental or nervous disorders, psychiatric disorders, or substance abuse. Facility Services do not include long-term, non-acute care.

Healthy Families. A state-sponsored insurance program offering low-cost health, dental and vision coverage to children of low-income, working families. Healthy Families health care professionals are contracted under a separate and distinct Healthy Families contract agreement. Healthy Families is also a product covered under the behavioral health network.

HIPAA. The Health Insurance Portability & Accountability Act of 1996 protects employees' health insurance coverage when they change or lose their jobs and provides standards for patient health, administrative and financial data interchange, governing the privacy and security of health information records and transactions. HIPAA, developed by the Department of Health and Human Services, took effect in 2001 with compliance required in phases up to 2004.

Home Health Agency (HHA). The following services are provided by a HHA:

1. Skilled nursing services
2. Services of a licensed therapist for physical, occupational or speech therapy
3. Services of a medical social worker
4. Services of a home health aide
5. 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.

Hospital Services. Acute care inpatient and hospital outpatient services that are covered by a *Prudent Buyer Plan Benefit Agreement.* Hospital services do not include long-term, non-acute care.

ICD-9 (International Classification of Diseases, 9th Revision). Providers use ICD-9 codes when reporting clinical diagnosis and classification of procedures. Anthem will use ICD-9 or successor codes.

ICD-10 (International Classification of Diseases, 10th Revision). ICD-10 Procedures and Diagnosis codes.

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. These encounters are usually comprised of coordinated and integrated multi-disciplinary services. The range of services is designed to address a mental or chemical (substance) use disorder and could include group, individual, family or multi-family group psychotherapy, psychoeducational services, and adjunctive services such as medical monitoring [although treatment for chemical (substance) related disorders typically includes involvement in an anonymous-based self-help program, such as Alcoholics Anonymous or Narcotics Anonymous, program time as described here excludes time spent in anonymous-based self-help programs, which are offered by community volunteers without charge]. Intensive Outpatient Programs must be supervised by a licensed behavioral health professional.

Interactive Voice Response (IVR). An automated computer system that stores and relays the most current eligibility, benefits and claims data for a Covered Individual. The IVR also provides claims status information.

Managed Care Network. The network of health care professionals who enter into contracts with Anthem Blue Cross and/or one or more of its affiliates. Health care practitioners agree to participate in the Anthem Blue Cross programs that are conducted pursuant to Benefit Agreements.

Medical Products and Services. The medical products and services network includes the following:

1. Medical supplies
2. Durable medical equipment (DME)
3. Orthotic appliances
4. Prosthetic devices and services
5. Hearing aid centers
6. Oxygen equipment and supplies

Major Risk Medical Insurance Program (MRMIP). A program that provides comprehensive managed care coverage for individuals unable to obtain insurance due to high-risk medical conditions. The state program is administered by Anthem Blue Cross.

Medical Services. Services provided by a health care professional.

Medicare Advantage (MA) Plan. Previously known as Medicare + Choice, a MA plan was designed to provide more choices for Medicare beneficiaries. Everyone who has Parts A and B of Medicare is eligible to enroll in a MA plan except those who have end-stage renal disease (ESRD) (unless certain exceptions apply).

Medicare Allowed Amount. A charge limit determined by the Centers for Medicare & Medicaid Services (CMS) and administered in accordance with Medicare guidelines.

Mental Disorders. Those conditions that affect thinking, perception, mood and behavior. A Mental Disorder is recognized primarily by symptoms or signs that appear as distortions of normal thinking, distortions of the way things are perceived, moodiness, sudden and/or extreme changes in mood, depression, and/or unusual behavior such as depressed behavior or highly agitated or manic behavior.

Mental Disorders are defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM). Mental Disorders include, but are not limited to, the following: schizophrenia, schizoaffective disorders, depressive, phobic and anxiety conditions (including panic disorders); bipolar affective disorders including mania and depression; obsessive-compulsive disorders; hypochondria, personality disorders (including paranoid, schizoid, dependent, anti-social and borderline); dementia and delirious states; post-traumatic stress disorder; adjustment reactions; reactions to stress; eating disorders such as anorexia nervosa and bulimia and substance use disorders. Any condition meeting the definition is a Mental Disorder no matter what the cause of the condition may be. One or more of these conditions and other conditions may be specifically excluded in the Benefit Agreement.

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 Blue Cross to provide medical services to Covered Individuals for prospectively determined rates.

Nonparticipating Provider. A health care professional who has not entered into a written Agreement with Anthem Blue Cross to provide medical services to Covered Individuals for prospectively determined rates.

Occupational Medicine Network. An Anthem Blue Cross health care delivery network that provides health services to injured workers covered by an insured or self-insured Workers' Compensation plan.

Occupational Therapy. A treatment modality 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. Persons or entities using the Prudent Buyer Plan Network and/or the Blue Cross Select PPO Network pursuant to a contract with Anthem Blue Cross, including, without limitation, other Anthem Blue Cross and/or Blue Shield plans, self-administered or self-insured programs providing health care benefits, employers or insurers. For a list of *Other Payors (Network Leasing)*, refer to *Appendix B* 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 *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 as of October 3, 2009, mandated by Federal legislation (Federal Mental Health Parity) for employer groups of 51 or more employees. The Final Parity Law , passed in 2010, became effective July 1, 2014 and as plans roll over throughout the year until January 1, 2015, when the Final Parity Law affects all plans; large group, small group and individual plans.

Partial Hospitalization Program. Structured and medically supervised day treatment programs. Program services are provided for no less than six hours a day, but usually no more than eight hours a day, and at least five days per week. The services are of essentially the same nature and intensity (including medical and nursing) as would be provided in a hospital, except that the patient is in the program less than 24 hours per day. The patient is not considered a resident in the program. The range of services offered is designed to address a behavioral health and/or substance related disorder through an individualized treatment plan provided by a coordinated, multi-disciplinary treatment team.

Participating Hospital. A hospital that has a written Agreement to provide hospital services as a participating health care Provider.

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 Facility, physician or other health care professional that has an Agreement with Anthem Blue Cross to provide health care services for prospectively determined rates.

Physical Therapy. A treatment modality specializing in functional activities, mobility training, manipulations, instruction, or other therapeutic exercises and services, including pediatrics.

Point-of-service (POS). The Covered Individual, at the point of accessing services, selects services from a HMO health care professional, preferred health care professional or a non-contracting health care professional. There are different benefit levels associated with the kind of health care professional selected by the Covered Individual, and some contracts do not provide any benefits for non-contracting health care professionals. Anthem Blue Cross POS is an Anthem Blue Cross point-of-service plan.

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 Covered Individuals 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 Blue Cross Covered Individuals. 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 Covered Individuals ages 19 and over
5. Immunizations given as standard medical practice for Covered Individuals ages seven through 18, except for hepatitis B and varicella zoster; tetanus immunizations for Covered Individuals ages 19 and over, if none received in previous 10 years; and influenza vaccines, when medically appropriate for Covered Individuals ages 19 and over
6. Vision and hearing exams for Covered Individuals 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 doctor designated by an HMO or other managed health care company to be the first physician a patient contacts for any medical problem. The doctor acts as the patient's regular physician and as a gate-keeper who determines if the patient needs to see a specialist or requires hospitalization.

ProviderAccess®. Accessed through the Anthem Blue Cross website, ProviderAccess enables health care professionals to check Anthem Blue Cross proprietary information online: provider2.anthem.com/wps/portal/ebpmybcc.

Provider Data Management (PDM). A department within Anthem Blue Cross that facilitates the data maintenance of Provider information for our entire Network of Providers.

Prudent Buyer Comp Provider Network. An Anthem Blue Cross health care delivery network under the Prudent Buyer Plan Network that provides health services to injured workers covered by an insured or self-insured Workers' Compensation plan.

Prudent Buyer Plan Benefit Agreement. A Benefit Agreement pursuant to which Covered Individuals have a financial incentive to use participating health care professionals.

Prudent Buyer Plan Network. The largest Preferred Provider Organization (PPO) in California. The network of health care Providers that have contracts with Anthem Blue Cross and/or one or more of its affiliates, pursuant to which those health care professionals have agreed to participate in the Prudent Buyer Plan (Blue Cross PPO) and other programs that are conducted pursuant to Benefit Agreements. The

Prudent Buyer Plan offers Covered Individuals the ability to choose more than one physician from the network, depending on the services required. Covered Individuals may self-refer to any physician in the network. Benefit plans are designed with financial incentives for Covered Individuals to use health care Providers that participate in the Prudent Buyer Plan Network. National and global coverage is provided through the BlueCard program

Self-Funded. When a business funds a benefit plan from its own resources rather than purchasing insurance.

Skilled Nursing Facility (SNF). A network of freestanding, subacute care Facilities that provide services such as:

1. Physical, occupational and speech therapy
2. Nasogastric or gastrostomy tube feedings
3. Total parenteral nutrition
4. Tracheostomy care
5. Hemodialysis
6. Ventilator care
7. Complex medication administration

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 (UM) 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. A treatment program designed to help patients regain and increase their ability to communicate through speech. Speech therapy is therapy that helps people to regain some speech after an accident or illness that has taken their speech away. Speech therapy can also help children if their speech is delayed.

Substance Abuse Disorders. Conditions including, but not limited to: psychoactive substance induced mental disorders; psychoactive substance use dependence; and psychoactive substance use abuse 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 Covered Individual for a medical service that is not approved by the applicable state regulatory authority, and is neither disclosed nor provided for in the Covered Individual'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 Covered Individual.

Telehealth. Telehealth means the mode of delivering health care services and public health utilizing the combination of HIPAA compliant information and communication technologies to enable the diagnosis, consultation, treatment, education, care management and self-management of patients at a distance from health care Providers. Telehealth does not include the use of audio-only telephone, facsimile machine, or email pursuant to the Provider and/or the Covered Individual contract. For more information refer to *Telehealth* section within this Manual.

Third-party Administrator. See the definition for "Other Payors." For a list of *Other Payors (Network Leasing)*, refer to *Appendix B* in this Manual.

Urgent Examination. An examination performed by a physician for a Covered Individual with a non-life-threatening condition that could lead to a potentially harmful outcome, if not treated within 24 hours.

Utilization Management (UM). 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.

Workers' Compensation. A statutory program that provides specific benefits for workers who suffer an injury in the course of, or arising out of, their employment.

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

360° Health®

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360° Health®

In addition to our *Quality Improvement Programs* initiatives, Anthem Blue Cross actively works to help improve our Covered Individuals' health by offering both preventive health and disease management programs.

360° Health is a unique care management program that surrounds and engages Covered Individuals with comprehensive, integrated health programs and services – ultimately driving greater program participation, lower health care costs, and better overall Covered Individual well-being and satisfaction.

360° Health offers a wide-ranging suite of programs, services, and tools, including preventive care, wellness information, savings and discounts, and case management services – all designed to deliver the right services to the right Covered Individuals at the right time.

To view a complete listing and description of all programs, please visit the Anthem Blue Cross website at anthem.com/ca, and select the "Health Information" link. The following are some examples of 360° Health programs.

Preventive Health and Education Programs

The preventive health programs are designed to encourage Covered Individuals to take an active role in their health, and educate Covered Individuals about their health care. It is our belief that self-awareness and responsibility are the keys to developing healthier lifestyles. Preventive health programs can offer many benefits to the Covered Individual, including:

1. Helping to increase understanding of personal health, as well as improve adherence to physician-prescribed treatment plans
2. Helping to increase the early detection of conditions and diseases
3. Helping to decrease health care services associated with treating acute and chronic (but preventable) conditions
4. Helping to increase Covered Individual satisfaction with the comprehensiveness of care received
5. Helping to increase Covered Individuals' confidence in the vital role they play in maintaining and improving their own health
6. Helping to provide positive exposure to the "team" approach to health care

Preventive Health Guidelines

The Preventive Health Guidelines are based in part on suggestions from independent groups including, but not limited to, The American Academy of Family Physicians, The American Academy of Pediatrics, The Advisory Committee on Immunization Practices, The American College of Obstetrics and Gynecology, The American Cancer Society, The Centers for Disease Control and Prevention, and The United States Preventive Services Task Force. The document includes recommended screening and immunization guidance for average risk children, teens, women, men and pregnant females.

This preventive health guideline 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.

We are committed to helping improve the quality and delivery of preventive services to our Covered Individuals. The Anthem Blue Cross Preventive Health Guidelines for healthy children, adolescents and adults are developed using nationally recognized recommendations from the U.S. Preventive Services Task Force (USPSTF), the American Academy of Pediatrics and the American Academy of Family Practitioners, among others. These guidelines are annually updated.

The current Preventive Health Guidelines can be viewed and printed at our website anthem.com/ca, or just click here.

Future Moms (Maternity Management Program)

Note: This program is currently only available to group health plan Covered Individuals. To verify if the Covered Individual is eligible for Future Moms program services, call 800-828-5891.

The Future Moms program, directed at both normal and high-risk pregnancies, promotes early assessment and intervention. Program components include maternity-risk assessments, health education and proactive benefits management. Through a toll-free phone number, 800-828-5891, registered nurses help mothers-to-be across the nation better understand their condition and the vital role they play in their own health.

The key component of the Future Moms program is the Covered Individual benefit management approach. The program consists of an assigned nurse care manager for each Covered Individual, who is also supported by pharmacists, registered dietitians, health educators and medical directors. The nurses take into consideration all corollary conditions, not just the pregnancy. This one-on-one relationship with a nurse is a key to helping to achieve the behavior change that is so critical in maternity management.

Program Process and Key Elements

The Future Moms program addresses the significant problems associated with high-risk pregnancies and premature births through a comprehensive strategy that involves:

- Telephone assessment and risk stratification for each Covered Individual
- Education concerning proper self-care, nutrition, and signs and symptoms of preterm labor
- Coordination of health care benefits and ancillary referrals
- Lifestyle management and behavioral change counseling
- Co-morbidity management
- Pharmacy and nutritional counseling
- Actionable materials that reinforce compliance and self-management, and provide easy-to-understand insight into pregnancy-related topics, such as health, safety and symptoms of complications
- Postpartum telephone contact to determine:
  - The birth outcome
  - Screen new mothers for Postpartum Depression and provide referrals as necessary
  - Education needs concerning the appropriate times for routine post-delivery care for mother and baby

Physician Communication

Ongoing physician communication is an essential part of the Future Moms program, and helps ensure that the Physician understands the needs of his or her patients. The Covered Individual's physician receives written introductory communication about the Future Moms program and notification that the individual has enrolled in the program.

This communication includes a toll-free number so physicians can call with questions or requests for information. Future Moms' nurses also facilitate effective communication between Covered Individuals and their physicians. The physicians are contacted on an as-needed basis, depending on issues identified during interviews, follow-up calls and educational sessions. If extra-contractual benefits are recommended, maternity management nurses verbally outline their recommendations to the physician and then send a confirmation letter upon service approval.

How to Make a Referral to Future Moms

Covered Individuals may enroll or get more details about this program by calling 800-828-5891. The Future Moms team is happy to answer any questions.

ConditionCare (Disease Management)

Note: The ConditionCare programs are currently only available to Covered Individuals. To verify whether a Covered Individual is eligible for any of the ConditionCare programs, call 877-681-6694.

The ConditionCare programs are designed to help maximize Covered Individuals' knowledge of their health status, improve health outcomes and control health care expenses associated with the following prevalent conditions:

- Asthma (pediatric and adult)
- Diabetes (Type I and Type II, pediatric and adult)
- Heart failure (HF)
- Coronary artery disease (CAD)
- Chronic obstructive pulmonary disease (COPD)

Each program is based on nationally recognized and evidence-based guidelines that support Covered Individual self-management. Using state-of-the-art technology, evidence-based practice guidelines, and trained and knowledgeable health care professionals, a Care Plan is provided for every identified Covered Individual telephonically managed in the care management program. Covered Individuals identified, but not telephonically managed due to their lower risk, are provided condition-specific educational materials and an opportunity to call for telephonic management if they so desire. This strategy helps us focus on an appropriate level and timely application of evidence-based interventions necessary for the successful and cost-effective management of the condition.

Furthermore, the ConditionCare programs support the physician/patient relationship, the physician's plan of care, and empower Covered Individuals to become more effective self-managers of their own health. Condition-specific educational materials also reinforce program interventions and further assist Covered Individuals with controlling their condition.

Covered Individual Eligibility and Identification

Through claims and pharmacy data analysis, eligible Covered Individuals are identified and enrolled into the ConditionCare programs. This process encompasses the review of:

- Paid medical claim International Classification of Disease (ICD)-9 and Current Procedural Terminology (CPT) codes
- Appropriate medications via National Drug Code (NDC)
- Laboratory reports
- Complementary program referrals (e.g., 24/7 NurseLine, Case Management and client EAP)
- Physician referrals
- Self-referrals
- Referrals from the health plan

Covered Individual Stratification

Through the application of a predictive modeling process, the ConditionCare programs' model is designed to stratify Covered Individuals into risk categories, so that the highest level of resources can be applied to the optimal population. The ConditionCare programs address these Covered Individuals through a combination of cost-effective interventions, which provide additional support for Covered Individuals and their Physicians.

Targeted Individualized Interventions

Identified Members receive an introductory letter explaining program benefits. For low-risk Members, the letter includes a toll-free number by which they can request a condition-specific educational booklet. High- and moderate-risk Members are automatically sent a condition-specific educational booklet and receive a follow-up enrollment call from a health outreach specialist. A nurse care manager then works with the Member to set personal health goals.

Enrolled Covered Individuals have access to the following resources:

- 24-hour inbound calling
- Condition-specific assessment
- Bilingual nurses and network services language line
- Condition-specific education packet
- Condition-specific education newsletter
- Ancillary Health Care Professional consultations

Outcomes

ConditionCare program planning begins with realistic, specific, and measurable outcomes, and we research and explore various methodologies to measure these outcomes. Measuring outcomes helps to:

- Establish benchmarks for program efficacy
- Evaluate intervention effectiveness

The ConditionCare programs measure the success of their services in the following areas:

1. Humanistic. Humanistic measures include Covered Individuals' self-reported perceptions of access to ConditionCare services, the value of information received, the overall value of the ConditionCare program, satisfaction with the ConditionCare program (including the staff) and utilization patterns.
2. Utilization. Utilization measures include inpatient hospital admissions and days, as well as emergency department visits. Measurements are based on utilization review data.
3. Clinical. Clinical measures vary among condition-specific programs, but generally include medication adherence (from pharmacy claims) and laboratory values (if available).

Medical Policy

Medical Policy Formation 2
Medical Policy and Clinical Utilization Management (UM) Guideline Distinction 3

Medical Policy Formation

The Anthem Blue Cross Medical Policy Subcommittee (MPS) of the Physician Relations Committee (PRC) is the authorizing body for Anthem Blue Cross medical policy and clinical Utilization Management (UM) guidelines (collectively, "Medical Policy"), 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. The principal component of the process is the review for development of Medical Necessity and 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. Voting membership includes: external physicians in clinical practices and participating in Networks; external physicians in academic practices and participating in Networks; internal medical directors; and Chairs of MPTAC Subcommittees. Non-voting members include internal legal counsel.

Medical Policy approved at MPTAC meetings are then further reviewed by the Anthem Blue Cross MPS of the PRC. The MPTAC approved Medical Policy position statements or clinical indications that are approved by the MPS are implemented in California (see below regarding clinical UM guidelines). The MPTAC approved Medical Policy position statements or clinical indications 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 that 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.

The committee(s) is also responsible for reviewing and authorizing the use of Medical Policy used in making determinations of Medical Necessity or investigational determinations, which are developed by external entities (for example, MCG™ or InterQual® criteria). These guidelines are also reviewed by the Anthem Blue Cross MPS. Clinical UM guidelines that are approved by MPS may be implemented in California while clinical UM guidelines that are not approved by MPS will not be implemented in California.

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.

All existing Medical Policies are reviewed at least annually to determine continued applicability and appropriateness and to determine whether there is a need for revision, updated citations, etc. and are re-approved through MPTAC.

Medical Policies developed by MPTAC are also communicated throughout Anthem Blue Cross for inclusion in the benefit package and for implementation of 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, Covered Individuals and the public in general. To access these documents on the anthem.com/ca website, select “Providers”, then Enter” to enter the site, then select “Enter” under “Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements, View requirements for Local Plan and BlueCard Out-of-Area Members.” Select “Medical Policies and Clinical UM Guidelines (for Local Plan Members).” Click on “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, click 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, click the appropriate letter to be redirected. Search functionality is also available.

Medical Policy and Clinical Utilization Management (UM) Guideline 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 websites. This provides greater transparency for Providers, Covered Individuals and the public in general.

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 Covered Individual's Blue Plan.

If Provider or Facility provides Covered Individuals' 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 Covered Individual'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 Covered Individual'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 Covered Individual for statutorily excluded service and the Covered Individual 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 – Please 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* ***not*** be used when submitting:

- Commercial Claims
- Federal Employee Program Claims
- Inpatient institutional Claims. Please 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 Covered Individuals will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Covered Individual.

Providers and Facilities can call the E-Solutions Help Desk at 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, please contact the Provider Customer Service phone number on the back of the Covered Individual's ID card.

Medicare Advantage

Medicare Advantage 2
Anthem Medicare Preferred PPO 2
Senior Secure HMO 2
Additional Information 2

Medicare Advantage

This section provides an overview of the Medicare Advantage products offered by Anthem Blue Cross. We have also provided a link to additional information, which will assist you with becoming familiar with our Medicare Advantage products, participation requirements, and provide access to other important information such as Provider Manuals, summary of benefits and prescription drug Formulary.

Website link for more information: anthem.com/ca/medicareadvantage

Anthem Medicare Preferred PPO

Anthem Blue Cross Life and Health Insurance Company is a Medicare Advantage Preferred Provider Organization (PPO) plan available to Medicare beneficiaries in California.

- Anthem Medicare Preferred allows its Members to use the service of any physician, hospital or other Providers within the plans network
- Anthem Medicare Preferred Members can also use non-network Providers, however the Member cost are higher
- Preauthorization is required for specific services
- Anthem Medicare Preferred features a Medicare Part D prescription drug benefit

Senior Secure HMO

Medicare Advantage HMO health plan offered within a select service area that features all of the health coverage services offered by Medicare, plus some extra services Medicare does not offer, such as annual physical exams, vision or a fitness center benefit.

- Members must see non-emergency care from network Providers
- Preauthorization requirements apply for specific services
- Senior Secure HMO includes a Medicare Part D prescription drug benefit

Website link for more information: anthem.com/ca/medicareadvantage

Additional Information

Please click here to view the HMO/PPO Medicare Advantage Provider Guidebook. Website link for more information: anthem.com/ca/medicareadvantage

Anthem 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." The complete *Anthem Centers of Medical Excellence (CME) Manual* can be found in the *Exhibits* section.

For the purposes of the Anthem Blue Cross Professional Manual, the following products will have access to the Network:

- Blue Cross PPO
- Blue Cross Select PPO
- Blue Cross Select HMO
- Blue Cross Senior Secure
- Anthem Medicare Preferred PPO

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 *Anthem Blue Cross Comprehensive Contracting Hospital Agreement* and the Anthem Blue Cross Facility Agreement between you and Anthem Blue Cross. Refer to your contract for specific information to product, type and exceptions.

The Anthem Centers of Medical Excellence 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.

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

Centers of Medical Excellence

Anthem Blue Cross 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). Anthem Blue Cross Covered Individuals have access through this program to CME, including Blue Distinction Centers for Specialty Care for transplant, bariatric surgery, cardiac care and complex and rare cancer, spine surgery and knee/hip replacements.

For transplants, Covered Individuals also have access to the Anthem CME 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.

Transplant

- The Blue Distinction Centers for Transplant (BDCT) program was launched in 2006. To date, approximately 100 Blue Distinction Centers for Transplant have been designated, representing more than 400 specific transplant programs across the country.
- The selection criteria for designation were developed in collaboration with 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).
- The Anthem Centers of Medical Excellence (CME) Transplant Network is a wraparound network to the BDCT program and offers WellPoint 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, and combined kidney/pancreas and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® were launched in January 2006.
- The American Heart Association estimates that 1.2 million Americans will experience a first or recurrent heart attack each year. 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). To date, we have designated approximately 500 Blue Distinction Centers for Cardiac Care across the country.
- Blue Distinction Centers for Cardiac Care® have demonstrated their commitment to quality care, resulting in better overall outcomes for cardiac patients. Each Facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American College of Cardiology (ACC) and the Society of Thoracic Surgeons (STS), and is subject to periodic reevaluation as criteria continue to evolve.

Bariatric Surgery

- Morbid obesity is widely recognized as a contributor to serious health risks. According to the Agency for Healthcare Research and Quality (AHRQ), between 1998 and 2004, the total number of bariatric weight-loss surgeries increased nine times, from 13,386 to 121,055. Blue Distinction® provides objective information to help patients make informed decisions when choosing a Provider.
- Blue Distinction Centers for Bariatric Surgery® launched in 2008, have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric surgery patients. They offer comprehensive bariatric surgery care services, including inpatient care, post-operative care,

outpatient follow-up care and patient education. To date, we have designated approximately 350 Facilities nationwide that meet our evidence-based selection criteria. In determining the selection criteria for Blue Distinction, we collaborated with physician experts and medical organizations such as the American College of Surgeons (ACS), American Society for Metabolic and Bariatric Surgery (ASMBS) and the Surgical Review Corporation (SRC).

Complex and Rare Cancers

- Complex and rare cancers comprise approximately 15 percent of new cancer cases each year. Blue Distinction Centers for Complex and Rare Cancers® are the first in a line of anticipated Blue Distinction Centers® focused on cancer treatment.
- Blue Distinction Centers for Complex and Rare Cancers were launched in 2008 and offer access to 90 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.
- 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 and have demonstrated their commitment to quality care, resulting in better overall outcomes for spine surgery patients. Each Blue Distinction® Facility meets objective clinical measures that are developed with input from expert physicians and medical organizations. To date, we have designated approximately 310 Facilities across the country as Blue Distinction Centers for Spine Surgery that provides comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.

Knee and Hip Replacement

- Blue Distinction Centers for Knee and Hip Replacement launched in November 2009 and provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries. To date, we have designated approximately 540 Facilities nationwide as Blue Distinction Centers for Knee and Hip Replacement.

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Dispute Resolution Process for Contracted Providers

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Dispute Resolution Process for Contracted Providers 2
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Information for Contracted Providers – Provider Dispute Process

The Department of Managed Health Care (DMHC) promulgated regulations known as the Claims Settlement Practices and Dispute Resolution Mechanism Regulations (Claims and Dispute Regulations), which can be found in *Title 28* of the *California Code of Regulations, Sections 1300.71 and 1300.71.38*. These regulations require 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 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* and *1300.71.38* of *Title 28* of the *California Code of Regulations*.

Dispute Resolution Process for Contracted Providers

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

1. Definition of Contracted Provider Dispute. A contracted Provider dispute is a Provider's written notice to Anthem Blue Cross 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 or seeking resolution of a contract dispute (or multiple group of substantially similar contractual disputes that are individually numbered); or disputing a request for reimbursement of an overpayment of a claim. Each contracted Provider dispute must contain, at a minimum, the following information: Provider's name, ID 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 Blue Cross on a claim, the following must be provided:
      - A clear identification of the disputed claim
      - The date of service
      - A clear explanation of the basis for which the Provider 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 ID 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

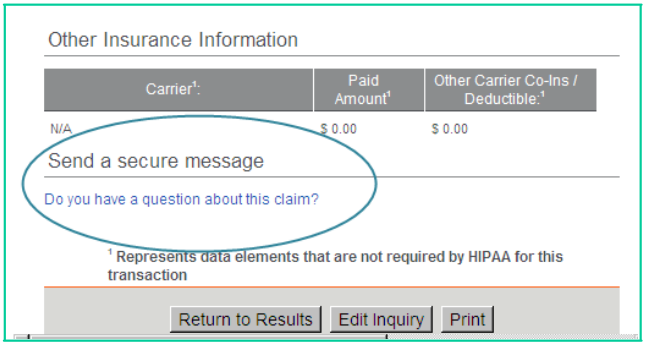
2. Secure Messaging – Availity Web Portal (Availity) The Availity Web Portal provided the opportunity to "ask a question" about a claim online. You can send a detailed question to clarify the status of a claim or to get additional information on a claim. Secure Messaging is a feature accessed at www.availity.com.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

   Note: If you received a bar-coded mail-back letter regarding a claim, please do not use Secure Messaging to respond. Instead, please 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:

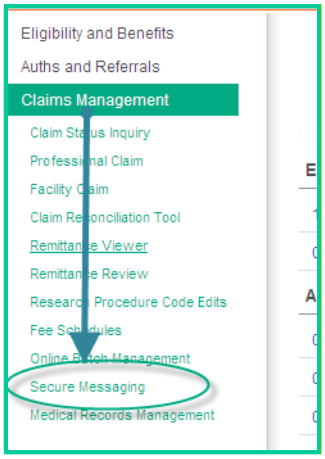
   - Click on the link "Do you have a question about this claim?"



   - 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 click "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 Blue Cross 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 Management 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

Sending a Contracted Provider Dispute to Anthem Blue Cross. Each contracted Provider dispute submitted to Anthem Blue Cross must include the information listed. The *Provider Dispute Resolution Request* form is available in the *Exhibits* section of this Manual, on ProviderAccess at anthem.com/ca, or by calling the Customer Service number referenced on the Covered Individual's ID card.

Contracted Provider disputes must be sent to the following address:

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

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

Blue Shield of California
P.O. Box 272510
Chico, CA 95927

3. Time Period for Submission of Provider Disputes:
   a. Contracted Provider disputes must be received by Anthem Blue Cross no later than 365 days from Anthem Blue Cross' action that led to the dispute; or
   b. In the case of inaction, contracted Provider disputes must be received by Anthem Blue Cross 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 Blue Cross within 30 working days of the returned receipt date.

4. **Acknowledgment of Contracted Provider Disputes.** Anthem Blue Cross will acknowledge receipt of all contracted Provider disputes within 15 working days of the date of receipt.
5. **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 Blue Cross by "Type of Plan" at the telephone numbers listed in the "Claims and Correspondence Mailing Address" subsection of the *Directory of Services*.
6. **Instructions for Filing Substantially Similar Multiple Contracted Provider Disputes.** You can use the *Provider Dispute Resolution Request* form available on ProviderAccess at anthem.com/ca or call the Anthem Blue Cross Customer Service number referenced on the Covered Individual's ID 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
7. **Time Period for Resolution and Written Determination of Contracted Provider Dispute.** Anthem Blue Cross will issue a written determination stating the pertinent facts and explaining the reasons for its determination within 45 working days after the date of receipt of the 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.
8. **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 Blue Cross will pay any outstanding monies calculated to be due, as well as all interest and penalties required by law or regulation, within five working days of the issuance of the written determination. For more information concerning claims submission instructions and claims settlement practices, refer to the *Claims Submission* section of this Manual.

Following the Provider Dispute Resolution Process, if you continue to disagree with Anthem Blue Cross' 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 conference. The following procedures are applicable to all meet and confer requests submitted to Anthem on or after the effective date of this Manual.

Please 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
Woodland Hills, CA 91367

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

Blue Shield of California
P.O. Box 272510
Chico, CA 95927

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

The party requesting the meet and confer (Requesting Party) shall provide all documentation and materials upon which it bases its position in the meet and confer. Any meet and confer request made by the Provider shall, at a minimum, contain the following information related to each patient claim that is the subject of the meet and confer request: (1) patient's name, (2) patient's Anthem Blue Cross ID number, (3) applicable date(s) of service, (4) a copy of the written determination that was made by Anthem Blue Cross on the dispute when it was submitted to the Anthem Blue Cross 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 patient claim determination made by Anthem Blue Cross 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 patient's complete medical records for the date(s) of service in 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 *Exhibit* to this Provider 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 Agreement with Anthem.

Subject to any limitations that may be set forth in the 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 (1) Requesting Party.

If satisfactory resolutions still are not reached through the meet and confer process, the Provider agrees to arbitrate the dispute, as outlined in the Agreement. The Provider 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 Provider or Provider group is strongly encouraged to engage in the Provider Dispute Resolution Process and Meet and Confer Process in a timely manner.

Dispute Resolution and Arbitration

The substantive rights and obligations of Anthem and Provider 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 Provider Manual.

A. Cost of Non-binding Mediation: The cost of non-binding mediation will be shared equally between the parties, except that each party shall bear their own respective attorneys' fees and other costs.
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. An arbitration panel shall consist of one (1) arbitrator selected by Provider, one (1) arbitrator selected by Anthem Blue Cross 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 Agreement with Anthem Blue Cross 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 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.

Links

- Anthem Blue Cross – Contact Us
  www.anthem.com/ca
- Availity Web Portal (Availity) – single sign-on, multiple payer Provider portal!
  www.availity.com
- Behavioral Health Clinical UM Guidelines
  http://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
  http://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
  https://www.anthem.com/wps/portal/ca/provider?content_path=shared/f2/s0/t0/pw_b144271.htm&label=Centers%20of%20Medical%20Excellence&rootLevel=1&label=Centers%20of%20Medical%20Excellence
- Clinical Practice, Preventive Health and Behavioral Health Guidelines
  http://www.anthem.com/wps/portal/ca/provider?content_path=provider/f2/s2/t0/pw_a118333.htm&rootLevel=1&label=Practice%20Guidelines
- Federal Employee Program
  www.fepblue.org/
- Industry Collaboration Effort (ICE)
  www.iceforhealth.org
- Health Insurance Exchange Information
  https://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
  https://www.anthem.com/wps/portal/ca/provider?content_path=provider/f3/s2/t0/pw_a114250.htm&rootLevel=2&label=Medicare%20Eligible

- Medical Policy Formation
  www.anthem.com/ca/medicalpolicies/policies/mp_pw_a044135.htm
- 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
- ProviderAccess – secure, Provider portal that houses Anthem Blue Cross proprietary information.
  https://provider2.anthem.com/wps/portal/ebpmybcc
- 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

Audit

Anthem Audit Policy 2
Audit Appeal Policy 5
Pre-payment Review Policy 6

Anthem Audit Policy

This Anthem Audit Policy applies to Providers. If there is conflict between this Policy and the terms of the applicable 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 Provider Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider Agreement between Anthem and Provider.

Coverage is subject to the terms, conditions, and limitations of a Covered Individual'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 that describes the duties and obligations of Anthem and the Provider, and which contains the terms and conditions upon which Anthem will reimburse Provider for Health Services rendered by Provider to Anthem Covered Individual(s).
- Appeal means Anthem's review of the disputed portions of the Audit Report, conducted at the written request of a Provider and pursuant to this Policy.
- Appeal Response means Anthem's written response to the Appeal after reviewing all Supporting Documentation provided by Provider.
- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider, 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 that Anthem or its designee believes an overpayment has been made by Anthem 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 and Anthem, Audit Reports shall be sent to Provider in accordance with the Notice section of the Agreement.
- Business Associate 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 means an entity with which Anthem has a written Agreement.
- Provider Manual means the proprietary Anthem document available to Provider and Facility, which outlines certain Anthem Policies.
- Recoupment means the recovery of an amount paid to Provider, which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider, 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 Covered Individual's medical records or other Provider documentation that supports the Provider'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 will supply the requested documentation in the format requested by Anthem within thirty (30) calendar days of Anthem's request.
2. Scheduling of Audit. After review of the documents submitted, if Anthem or its designee determine an Audit is required, Anthem will call the Provider to request a mutually satisfactory time for Anthem to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. Rescheduling of Audit. Should Provider desire to reschedule an Audit, Provider must submit its request with a suggested new date, to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's rescheduling.
4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider may identify Claims for which Provider under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.
5. Scheduling Conflicts. Should the Provider fail to work with Anthem 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 in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider to schedule an Audit within the seventy-two (72) hour timeframe.
6. On-Site and Desk Audits. Anthem or its designee may conduct Audits from its offices or on-site at the Provider's location. If Anthem or its designee conducts an Audit at a Provider's location, Provider will make available suitable work space for Anthem'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 Covered Individual authorization. When conducting credit balance reviews, Provider will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider refuses to allow Anthem access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider policy to the contrary.

7. Completion of Audit. Upon completion of the Audit, Anthem or its designee will generate and give to Provider a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview, which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider, its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider disagree with the final Audit Report generated during the exit interview, then Provider may either supply the requested documentation, or Appeal the Audit findings.
8. Provider Appeal's. See Audit Appeal Policy.
9. No Appeal. If the Provider does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover 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 must comply with applicable state and federal record keeping requirements.

A. Confirm that Health Services were delivered by the Provider in compliance with the physician's plan of treatment.

   Auditors will verify that Provider's plan of treatment reflected the Health Services delivered by the Provider. The services are generally documented in the Covered Individual's health or medical records. In situations where such documentation is not found in the Covered Individual's medical record, the Provider 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 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 Covered Individual'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 Covered Individual's Claim. Other appropriate documentation for Health Services

provided to the Covered Individual may exist within the Provider'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 Covered Individual's Claim. The Provider 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 Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider disputes, as well as the basis for the Provider's belief that such finding(s) are not accurate. All findings disputed by the Provider in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.
2. A Provider'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 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 its 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 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 an Appeal Response to the Provider. Anthem's or its designee's response shall address each matter contained in the Provider'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 within thirty (30) calendar days of the date Anthem or its designee received the Provider's Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.
4. The Provider 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 response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee

shall begin recoupment for the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider.

5. Upon receipt of a timely Provider 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 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 within fifteen (15) calendar days of the date Anthem or its designee received the Provider 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 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. If no remittance check is received within the fifteen (15) calendar day timeframe, 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.
7. If Provider still disagrees with Anthem's or its designee's position after receipt of the final Appeal Response, Provider may invoke the dispute resolution mechanisms under the Agreement.

Pre-payment Review Policy

Purpose: To establish a method of prevention of fraud, waste or abuse through pre-payment review process.

Through a variety of means, certain health care Providers or certain Claims submitted by Providers may come to Anthem's attention for some reason or behavior that might be identified as unusual, or which indicates the Provider is an outlier as compared to similar peer. One method is through computer algorithms designed to identify billing practices or other factors indicating conduct that is unusual or outside the norm of a Provider's peers.

Once a Claim or a Provider is identified as an outlier, further investigation is conducted by SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim. If the investigation results in a determination that the Provider's actions may involve fraud, abuse or waste, the Provider is notified and given an opportunity to respond.

If, despite the Provider's response, Anthem continues to believe the Provider's actions involve fraud, abuse or waste, or some other inappropriate activity, the Provider will then be notified that pre-payment review will commence. Placement on pre-payment review requires the Provider to submit medical records with each Claim for Anthem to review medical records in comparison to the billed services. Failure to submit medical records to Anthem in accordance with this provision will result in a request for additional records in order to review and adjudicate the claim. Continued submission without medical records will ultimately result in denial of a Claim under review.

The Provider 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 Provider could face corrective measures, up to and including termination from our Provider network.

Finally, Providers are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, abuse, waste or any other billing issue, or for failure to submit medical records as set forth above. Providers whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable Provider Agreement and state law. Providers also may appeal such determination in accordance with applicable grievance procedures.

Telehealth

California Telehealth Services Bulletin 2
Billing/Coding 3

California Telehealth Services Bulletin

This Anthem Blue Cross California Telehealth Services Bulletin supports the requirements promulgated under California AB415 and is designed to retain consistency with the Enterprise Professional Reimbursement Policy (EPRP #0007) related to Telehealth and Telemedicine without conflicting with the AB415 California state mandates.

Telehealth means the mode of delivering health care services and public health utilizing the combination of HIPAA compliant information and communication technologies to enable the diagnosis, consultation, treatment, education, care management, and self-management of patients at a distance from health care Providers. Telehealth does not include the use of audio-only telephone, facsimile machine, or email pursuant to the Provider and/or the Covered Individual contract.

Telehealth is used to support health care when the Provider and patient are physically separated. The audio-video telehealth system used must, at a minimum, have the capability of meeting the procedural definition of the code provided through telehealth. The telecommunication equipment must be of a quality to adequately complete all necessary components to document the level of service for the CPT code billed. The audio-video system and peripheral equipment must provide adequate resolution or audio quality for decision-making by the Provider who is working at a different location from the patient.

The presentation/origination site is the place where the patient is located at the time of the telehealth service. The distant site is the place where the Provider is located at the time the service is provided.

1. Real time (synchronous) telehealth services may be eligible for separate reimbursement when such services are equivalent to similar services when rendered in-person (face-to-face) with the patient, with the following criteria applicable:
    a. A telehealth service must use interactive audio, video or data communication to qualify for reimbursement.
    b. The Evaluation & Management service must be in real-time or near real-time (delay in seconds or minutes) to qualify as an interactive two-way transfer of medical data and information between the patient and practitioner.
    c. The health care Provider who has the ultimate responsibility for the care of the patient must be licensed in the State of California.
    d. The Provider performing Evaluation & Management services via telehealth must be licensed in the state where the service was performed telemedically.
    e. The use of modifier GT does not alter reimbursement for the Current Procedural Terminology (CPT) or HCPCS code billed.
    f. A telephone conversation, an electronic mail message or facsimile transmission between a health care Provider and a patient will not be reimbursed pursuant to the Provider and/or Covered Individual contract.
2. Teleopthalmology and Teledermatology Store and Forward (asynchronous) telehealth services may be eligible for separate reimbursement when such services are equivalent to similar services when rendered in-person (face-to-face) with the patient, with the following criteria applicable:
    a. The images must be specific to the patient's condition and adequate for meeting the procedural definition of the national code that is billed.
    b. Services must be rendered by a physician who has completed training in an Accreditation Council for Graduate Medical Education (ACGME)-approved residency in ophthalmology or

dermatology respectively. Optometrists with ophthalmology training may provide screening services. If the reviewing optometrist identifies a disease or condition requiring consultation or referral, that consultation or referral shall be with an ophthalmologist or other appropriate physician and surgeon, pursuant to the California Business and Professions (B&P) Code and regulations.

c. A patient receiving teleophthalmology or teledermatology by store-and-forward shall be notified of the right to receive interactive communication with the distant specialist physician or optometrist, upon request. If requested, the communication may occur either at the time of consultation or within 30 days of the patient's notification of the consultation results.
d. Teleophthalmology and teledermatology does not include a telephone conversation, an electronic mail message, or facsimile transmission between a health care Provider and a patient.
e. The health care Provider who has the ultimate responsibility for the care of the patient must be licensed in the State of California.
f. The Provider performing Evaluation & Management services via telehealth must be licensed in the state where the service was performed telemedically.
g. The use of modifier GQ does not alter reimbursement for the CPT or HCPCS code billed.

3. In order for Telehealth services to be eligible for reimbursement, the Provider's services must be rendered in an appropriate setting using HIPAA compliant technologies pursuant to the Provider and/or Covered Individual contract.
4. Following are examples of services not eligible for reimbursement as Telehealth services:
   a. Non-direct patient services (e.g. coordination of care rendered before or after patient interaction).
   b. Services rendered by audio-only telephone communication; facsimile; email; or any other non-secure electronic communication pursuant to the Provider and/or Covered Individual contract.
   c. Any services that are not eligible for separate reimbursement when rendered to the patient in-person.
   d. Presentation/origination site Facility fee (except when developed to support a specific health plan initiative mandate).
   e. Distant site Facility fee (except when developed to support a specific health plan initiative mandate).
   f. Transmission costs (except when developed to support a specific health plan initiative mandate).

Billing/Coding

The following is provided as an informational tool only, to help identify some of the applicable CPT codes/code ranges and HCPCS codes/modifiers that may be utilized in reporting telehealth services. The inclusion or exclusion of a specific code does not indicate eligibility for reimbursement and/or coverage in all situations.

CPT codes that ordinarily describe direct face-to-face services, but signify telehealth services when used with Modifier GT or GQ:

- 99201-99215 – Office or other outpatient evaluation and management services
- 99241-99245 – Office or other outpatient consultations
- 90801-90802 – Psychiatric diagnostic interview examination
- 90804-90809 – Individual psychotherapy services
- 90862 – Pharmacologic management service

Category III CPT codes specific to telehealth:

- 0188T– Remote real-time interactive video conferenced critical care, evaluation, and management of the critically ill or critically injured patient; first 30-74 minutes
- 0189T– Remote real-time interactive video conferenced critical care, evaluation, and management of the critically ill or critically injured patient; each additional 30 minutes (list separately in addition to code for primary list)

HCPCS codes/modifiers:

- G0406 – Follow-up inpatient telehealth consultation, limited, physicians typically spend 15 minutes communicating with the patient via telehealth
- G0407 – Follow-up inpatient telehealth consultation, intermediate, physicians typically spend 25 minutes communicating with the patient via telehealth
- G0408 – Follow-up inpatient telehealth consultation, complex, physicians typically spend 35 minutes or more communicating with the patient via telehealth
- G0425 – Initial inpatient telehealth consultation, typically 30 minutes communicating with the patient via telehealth
- G0426 – Initial inpatient telehealth consultation, typically 50 minutes communicating with the patient via telehealth
- G0427 – Initial inpatient telehealth consultation, typically 70 minutes or more communicating with the patient via telehealth (new code effective 1/1/2010)
- GT – Modifier signifying: Via interactive audio and video telecommunications
- GQ – Modifier signifying: Via asynchronous telecommunications system

HCPCS codes/modifiers that are not eligible for separate reimbursement:

- G9002 – Distant site Facility fee
- Q3014 – Originating site Facility fee
- T1014 – Telehealth transmission, per minute, professional services bill separately

CPT codes that are not eligible for reimbursement:

- 98966-98968 – Telephone assessment and management by a qualified non-physician health care professional
- 98969 – Online assessment and management service provided by a qualified non-physician health care professional to an established patient, guardian or health care Provider not originating from a

related assessment and management service provided within the previous seven days, using the Internet or similar electronic communications network

- 99441-99443 – Telephone evaluation and management service provided by a physician
- 99444 – Online evaluation and management service provided by a physician to an established patient, guardian or health care Provider not originating from a related E/M service provided within the previous seven days, using the Internet or similar electronic communications network (except when developed to support a specific health plan initiative mandate)

Health Insurance Marketplace (Exchanges)

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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 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 Covered Individual 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. Go to anthem.com/ca > Providers > 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
- Under "Useful Tools" in the right margin
- Select the box titled "Find a Doctor" to search our online Provider Directory

Providers and Facilities who have questions on their participation status are encouraged to contact Network Relations at CAcontractsupport@anthem.com. Note: For Behavioral Health questions, contact BHNetworkRelations@anthem.com

If you are referring a Covered Individual to another provider or facility, please verify that the provider is participating in the Covered Individual's specific network.

It is critical that your patients receive accurate and current data related to provider availability. As outlined in your Agreement, please notify Anthem within 10 business days of all changes listed below. *Please note TAX ID changes must be accompanied by a W-9 to be valid.*

- Telephone number for Covered Individuals to schedule appointments at your practice location
- Practice/Facility location address

- Practice/Facility Office Hours
- Provider/Facility name
- Practice 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

Please send your change request information timely, preferably within 10 business days, in one of the following ways:

- Online form*: Physician/Physician Group Change Request Form*
- E-Mail Address: ProviderDatabaseAnthem@anthem.com
- • Fax Number: 818-234-2836 Address: P.O. Box 70000, Van Nuys, CA. 91470

Health Insurance Exchange Information Link

https://www.anthem.com/wps/portal/ca/provider?content_path=provider/f5/s4/t0/pw_e199856.htm&label=Health%20Insurance%20Exchange%20Information&rootLevel=4&

Exhibits

1. Advanced Patient Notice Form
2. Anthem Centers of Medical Excellence Manual
3. Appointment of Representative CMS
4. Continuity of Care/Transition of Care Request Form
5. Coordination of Care Form and Letter Templates:
   - Coordination of Care Form
   - Cover Letter for Behavioral Health Practitioners
   - Cover Letter for Medical
6. Covered Individual (Patient) Responsibility Agreement – Waiver Form
7. EOB – Explanation of Benefits Sample
8. Identification (ID) Card
   - Blue Cross Blue Shield Federal Employee Program
   - Blue Cross POS
   - Blue Cross PPO
   - Medicare Preferred PPO
   - Select PPO
9. Individual Authorization for Release of Protected Health Information Form
10. Manual Search Tool
11. Non-Member Transplant Donor Form
12. Outpatient Treatment Report
13. Patient Consent to Exchange Information
14. Practice Profile
15. Practice Update Form
16. Provider Dispute Resolution Request
17. Request for Prudent Buyer Plan Pricing
18. Severity Levels for Quality Assurance
19. Timely Filing Acceptable Forms of Proof

Provider Agreement Affiliates List

Anthem Blue Cross Life and Health Insurance Company
Anthem Health Plans of Kentucky, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Health Plans of Maine, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Health Plans of New Hampshire, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Health Plans of Virginia, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Health Plans, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Insurance Companies, Inc. DBA Anthem Blue Cross and Blue Shield
Anthem Kentucky Managed Care Plan, Inc. DBA Anthem Blue Cross and Blue Shield Medicaid
Anthem Life Insurance Company
Anthem Life & Disability Insurance Company
Blue Cross and Blue Shield of Georgia, Inc.
Blue Cross Blue Shield Healthcare Plan of Georgia, Inc.
Blue Cross Blue Shield of Wisconsin DBA Anthem Blue Cross and Blue Shield
Blue Cross of California DBA Anthem Blue Cross
Blue Cross of California Partnership Plan, Inc. DBA Anthem Blue Cross Partnership Plan
Claim Management Services, Inc. DBA Anthem Blue Cross and Blue Shield Community Insurance
Community Insurance Company DBA Anthem Blue Cross and Blue Shield
Compcare Health Services Insurance Corporation
Compcare Health Services Insurance Corporation DBA Anthem Blue Cross and Blue Shield
Empire HealthChoice Assurance, Inc. DBA Empire BlueCross BlueShield or Empire BlueCross
Empire HealthChoice HMO, Inc. DBA Empire BlueCross BlueShield HMO or Empire BlueCross HMO
HealthKeepers, Inc.
Healthy Alliance Life Insurance Company DBA Anthem Blue Cross and Blue Shield
HMO Colorado, Inc.
HMO Colorado, Inc. DBA HMO Nevada
HMO Missouri, Inc. DBA Anthem Blue Cross and Blue Shield
Matthew Thornton Health Plan, Inc. DBA Anthem Blue Cross and Blue Shield
RightCHOICE Managed Care, Inc. DBA Anthem Blue Cross and Blue Shield
Rocky Mountain Hospital and Medical Service, Inc. DBA Anthem Blue Cross and Blue Shield
UNICARE Health Plan of West Virginia, Inc.
UNICARE Health Plans of Texas, Inc.
UniCare Life & Health Insurance Company
WellPoint Partnership Plan, LLC

Anthem Blue Cross is the trade name of Blue Cross of California. Anthem Blue Cross and Anthem Blue Cross Life and Health Insurance Company are independent licensees of the Blue Cross Association. ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Rev 10/01/2014

Appendix B – Other Payors List (Network Leasing)

Network Leasing Arrangements

Anthem Blue Cross has network leasing arrangements with a variety of organizations, which we call Other Payors. Other Payors and affiliates use the Anthem Blue Cross Network.

Under the terms of your Provider Agreement, Members of Other Payors and affiliates are treated like Anthem Blue Cross Members. As such, they're entitled to the same Anthem Blue Cross billing considerations, including discounts and freedom from balance billing. You can obtain the Other Payors list on ProviderAccess®, which can be accessed through the Anthem Blue Cross website at anthem.com/ca.

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 ca/anthem.com/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.

Your rights

Under federal law, you have the right to:

- Send us a written request to see or get a copy of certain PHI, or 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.

EFFECTIVE Januarl/015

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Appendix D – Out-of-Network For Select PPO

Below is a listing of hospitals and other Providers, which do not participate in the Select PPO Network.

Service Type	Provider	County
ASC	The Surgery Center of Alta Bates	ALAMEDA
ASC	East Bay Endoscopy Center	ALAMEDA
HOSPITAL	Alta Bates Summit Medical Center - Alta Bates/Herrick Campus	ALAMEDA
HOSPITAL	Alta Bates Summit Medical Center - Summit Campus	ALAMEDA
HOSPITAL	Eden Hospital Medical Center	ALAMEDA
HOSPITAL	San Leandro Hospital Campus	ALAMEDA
SNF	Alta Bates Med Center - SNF	ALAMEDA
SNF	Alta Bates Summit SNF	ALAMEDA
SNF	Baywood Court SNF	ALAMEDA
SNF	Laurel Grove Hospital	ALAMEDA
SNF	San Leandro Hospital Campus - CORF	ALAMEDA
VNA	Sutter VNA/Emeryville	ALAMEDA
HOSPITAL	Sutter Amador Hospital	AMADOR
ASC	Walnut Creek Endoscopy Center LLC	CONTRA COSTA
HOSPITAL	Sutter Delta Medical Center	CONTRA COSTA
VNA	Sutter VNA & Hospice	CONTRA COSTA
ASC	Northbay Regional Surgery Center	MARIN
VNA	Sutter VNA/Marin	MARIN
HOSPITAL	Memorial Hospital of Modesto	MERCED
SNF	Memorial Hospital of Los Banos - RHC	MERCED
ASC	Sutter Roseville Endoscopy Center	PLACER
ASC	Sutter Auburn Surgery Center	PLACER
HOSPITAL	Sutter Auburn Faith Hospital	PLACER
HOSPITAL	Sutter Roseville Medical Center	PLACER
VNA	Sutter VNA	PLACER
VNA	Sutter VNA/Auburn	PLACER
VNA	Sutter VNA/Roseville	PLACER
ASC	Fort Sutter Surgery Center	SACRAMENTO
ASC	Sutter Alhambra Surgery Center	SACRAMENTO
ASC	Sutter River City Surgery Center	SACRAMENTO
HOSPITAL	Sutter General Hospital	SACRAMENTO
Psychiatry	Sutter Center for Psychiatry	SACRAMENTO
SNF	Sutter Oaks Nursing Center	SACRAMENTO
VNA	Sutter VNA/Sacramento	SACRAMENTO
ASC	Presidio Surgery Center	SAN FRANCISCO
ASC	San Francisco Endoscopy Center	SAN FRANCISCO
ASC	Sutter Street Endoscopy Center	SAN FRANCISCO

Appendix D – Out-of-Network For Select PPO

Service Type	Provider	County
ASC	Golden Gate Endoscopy Center	SAN FRANCISCO
SNF	California Pacific Medical Center - California Campus	SAN FRANCISCO
VNA	Sutter VNA/SF	SAN FRANCISCO
ASC	Stockton Surgery Center	SAN JOAQUIN
HOSPITAL	Sutter Tracy Community Hospital	SAN JOAQUIN
SNF	Home Health & Hospice of Sutter Tracy	SAN JOAQUIN
HOSPITAL	Mills Hospital	SAN MATEO
HOSPITAL	Peninsula Hospital & Medical Center	SAN MATEO
SNF	Burlingame Dialysis Center	SAN MATEO
SNF	Peninsula Hospital - SNF	SAN MATEO
SNF	Peninsula Hospital & Medical Center - Psych	SAN MATEO
SNF	Peninsula Hospital & Medical Center - Rehab	SAN MATEO
SNF	Peninsula Hospital & Medical Center CDRF	SAN MATEO
VNA	Sutter VNA/San Mateo	SAN MATEO
ASC	Santa Barbara Endoscopy Center LLC	SANTA BARBARA
ASC	Surgecenter of Palo Alto	SANTA CLARA
ASC	Camino Medical Group Ins Surgery	SANTA CLARA
HOSPITAL	Menlo Park Surgical Hospital	SANTA CLARA
HOSPITAL	Sutter Maternity & Surgery Center Of Santa Cruz	SANTA CRUZ
VNA	VNA of Santa Cruz	SANTA CRUZ
ASC	Sutter Fairfield Surgery Center	SOLANO
HOSPITAL	Sutter Solano Medical Center	SOLANO
SNF	Sutter Solano Medical Center - TCU	SOLANO
ASC	The Surgery Center of Santa Rosa	SONOMA
HOSPITAL	Sutter Medical Center Of Santa Rosa	SONOMA
SNF	Sutter Medical Center of Santa Rosa TCU	SONOMA
VNA	Sutter VNA/Santa Rosa	SONOMA
ASC	Briggsmore Specialty Center	STANISLAUS
HOSPITAL	Memorial Hospital of Los Banos	STANISLAUS
SNF	Memorial Hospital of Modesto	STANISLAUS
VNA	VNA of the Central Valley	STANISLAUS
ASC	Sutter North Procedure Center	SUTTER
ASC	Sutter North Surgery Center	SUTTER
HOME HEALTH	Sutter North Home Health	SUTTER
HOSPITAL	Sutter Davis Hospital	YOLO
HOSPITAL	Sutter Surgical Hospital - North Valley	YUBA
HOSPICE	Sutter North Hospice	YUBA

Summary of Changes

The Summary of 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 2015 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 July 6, 2015.

Section	Subsection	Changes
Introduction and Guide to Manual	Using This Manual	Revised: • 1st paragraph, 1st sentence: "those that bill on a *CMS-1500 Claim Form*, which are hereinafter referred to as "Providers") and their…" • Added content: "Effective on July 6, 2015"
Introduction and Guide to Manual	Manual Search Tool	Revised: • Entire subsection Revised: • "Manual Search Tool" exhibit
Introduction and Guide to Manual	Purpose and Introduction	Revised: • 3rd paragraph: "Note: The mouse icon will be used to indicate information accessible through the ProviderAccess® website at…" • 4th paragraph: "The mouse icon also indicates information accessible…" • 5th paragraph: "! You must have a ProviderAccess and Availity Web Portal…" • 6th paragraph: added "Availity" wording
Introduction and Guide to Manual	Included in This Manual	Revised: • 1st paragraph: "2015 Professional Manual is divided into the following 40 sections:" • Manual section renumbered
Introduction and Guide to Manual	Included in This Manual	! Revised section titles: • Section 4 – "ProviderAccess®" revised to "ProviderAccess® and the Availity Web Portal (Availity)" • Section 17 – "Medical Management" revised to: "Medical Management Programs" • Section 26 – "Medical Policies" revised to: "Medical Policy" • Section 32 – "Provider Audit" revised to: "Audit"

Section	Subsection	Changes
Introduction and Guide to Manual	Included in This Manual	!Added: Section 27 – Medicare Crossover Section 34 – Health Insurance Marketplace (Exchanges)
Introduction and Guide to Manual	Included in This Manual	Revised description: • Section 4 – ProviderAccess® and the Availity Web Portal (Availity) • Section 17 – Medical Management Programs • Section 19 – Quality Improvement • Section 40 – Summary of Changes
Directory of Services	Entire Section	Throughout this section revised departments and contact information were added
Directory of Services	Introduction	Revised: • 1st paragraph, 3rd sentence: "For additional information, access the Anthem Blue Cross…"
Directory of Services	Entire Section	Revised: • 360° Health Added: • Availity Web Portal (Availity) • Behavioral Health Medical Director • Behavioral Health Provider Relations • Behavioral Health Provider Resources Revised: • BlueCard® Eligibility and Membership Contact Information • California Department of Insurance (CDI) • Case Management/Disease Management • Centers for Medicare & Medicaid Services • Claims and Correspondence Mailing Addresses • Credentialing • Electronic Data Interchange (EDI) • Grievances and Appeals • Medicaid Managed Care • Medical Quality Management

Section	Subsection	Changes
Directory of Services	Entire Section	Revised: • National Provider Solutions (NPS) • Network Relations (formerly known as Network Relations and Service) • Overpayment Recovery Procedures • ProviderAccess® • Provider Care • Provider Data Management • Provider Network Education and eSolutions • Quality Improvement Programs • Utilization Management (UM) • Website Address • Workers' Compensation Services
Rights and Responsibilities	Participating Provider Responsibilities	Added: • 3rd bullet, "Confirm that the person presenting the Anthem identification card is in fact the Covered Individual."
Rights and Responsibilites	Provider Data Management (PDM)	• Added subsection
Rights and Responsibilities	Misrouted Protected Health Information (PHI)	• Added subsection
Rights and Responsibilities	Insurance Requirements	• Added subsection
Rights and Responsibilities	Risk Adjustments	• Added subsection
Rights and Responsibilities	Referrals to Nonparticipating Providers	Revised: • 2nd paragraph: "If the Provider must admit a Covered Individual to a nonparticipating hospital or mental health facility or refer…" Added: • 2nd paragraph: *Advance Patient Notice Form* Revised: • Line item 1: "The Provider is not participating…" • Line item 2: "The Covered Individual may be responsible for extra costs if he/she…"

Section	Subsection	Changes
Rights and Responsibilities	Referrals to Nonparticipating Providers	Revised: • Line item 3: "The Covered Individual can call Anthem before getting services to confirm his/her." • Line item 4: "The non-participating provider will collect co-payments, deductibles, coinsurance…" • Line item 5: "The Covered Individual is voluntarily choosing to get services from…"
Rights and Responsibilities	Referrals to Nonparticipating Providers	Revised subsection Provider also agrees: • 1st bullet: "If they refer a Covered Individual to a nonparticipating Provider, they will use" Added: • 2nd bullet: "For Workers' Compensation, please refer to…"
Rights and Responsibilities	Workers' Compensation	Revised: • 1st paragraph, added: "Other Payor"
Rights and Responsibilities	Guaranteed Payment to Providers	• Revised subsection
Rights and Responsibilities	Health Care Providers' Bill of Rights	• Revised subsection
Rights and Responsibilities	Covered Individual Rights and Responsibilities Statement	• Revised subsection
Rights and Responsibilities	Disclosure of Psychotherapy Notes	• Revised subsection
ProviderAccess® and the Availity Web Portal (Availity)	Entire Section	Added: • Availity content throughout section
ProviderAccess® and the Availity Web Portal (Availity)	Introduction	Revised subsection
ProviderAccess® and the Availity Web Portal (Availity)	Availity Web Portal (Availity)	• Added content

Section	Subsection	Changes
ProviderAccess® and the Availity Web Portal (Availity)	ProviderAccess® Portal	• Added content
ProviderAccess® and the Availity Web Portal (Availity)	Important Features of Secure Web Portal Access	Removed • Claim Follow-up content Revised: • Eligibility & Benefits (available ONLY on Availity): • Claim (available ONLY on Availity):
ProviderAccess® and the Availity Web Portal (Availity)	American Imaging Management® (AIM®)	• Revised content
Eligibility	Introduction	• Added Availity content
Eligibility	Identification (ID) Cards	Revised: • 1st Paragraph, last sentence: "Covered Individuals who lose or misplace their cards should be advised to call the…" Added: • Line item 10: "Telephone number for…"
Eligibility	Web-based Temporary Identification Card	Added: • 2nd paragraph: "If the Member is going through anthem.com or anthem.com/ca, then…"
Eligibility	Online Inquiry Using the Availity Web Portal	Added: • Availity content throughout subsection
Eligibility	Interactive Voice Response (IVR) Unit	Revised: • 1st paragraph: "non-Federal Employee Program…"
Eligibility	BlueCard® Eligibility and Benefits	Revised: • 5th paragraph: "ID cards from International BCBS Covered Individuals…" • 6th paragraph: "Covered Individuals with a "PPO in a suitcase" logo…" • Last paragraph: "click on this link, BlueCard® Program Provider Manual…"
Eligibility	Domestic Partners	• Revised 2nd paragraph: "Customer Service telephone number on the back of the…"

Section	Subsection	Changes
Eligibility		• Removed entire subsection: "Federal Mental Health Parity and Addiction Equity Act…"
Claim Submission	Information for Contracted Providers	Revised: • Information for Contracted Providers subsection: "Claim Submission Instructions:" • Line item 2: Calling Anthem Blue Cross Regarding Claims…or follow the instructions on the back of the Covered Individual are…" • Line item 4: "Claim Receipt Verification…"
Claim Submission	Information for Contracted Providers	Revised: • Line item 1, Claim Overpayment: "and the overpayment reason…"
Claim Submission	Information for Contracted Providers	• Removed: "Information for Nonparticipating Select PPO Providers" content
Claim Submission	General Guidelines	• Added line item 12: National Drug Code Requirements
Claim Submission		• Removed "Claim Re-process/Inquiry Request" content
Claim Submission	Secure Messaging – Availity Web Portal	• Added subsection
Claim Submission	Contacting the EDI Solutions Help Desk	• Revised phone number and email address
Claim Submission	Submitting & Receiving EDI Transactions	• Revised ERA/EFT – Contact Chart Contact information • Added last paragraph: "Should Provider or Facility elect to receive payments via EFT, such election may be…"
Claim Submission	Where and How to Submit BlueCard® Program Claims	• Added 4th paragraph: "We will work with the Member's Plan to process…" • Revised 5th paragraph: "We will send you an explanation of payment or the remittance advice…"
Claim Submission	Coordination of Benefits for FEP	• Added subsection

Section	Subsection	Changes
Claim Submission	FEP Program Requirements	Revised: • 1st paragraph: "The Anthem FEHBP encompasses the Blue Cross Blue Shield Association…" • 1st paragraph, added last two paragraphs: "When a conflict arises between federal and state laws and regulations, the…"
Claim Submission	Claim Submission Filing Limits	Revised: • Submission of Claims Under the Federal Employee Health Benefit Program Added: • FEHBP Waiver Requirements
Audiology/Hearing Aid	Introduction	Revised: • 1st paragraph: "This section outlines general billing guidelines for all Anthem Blue Cross…"
Audiology/Hearing Aid	Billing Requirements	Revised: 1st paragraph: "Anthem Blue Cross billing requirements…" Revised Audiology: • Line item c): "appropriate HCPCS or…" • Line item g): "For electronic billing provide the rendering…"
Home Infusion Therapy	Introduction	Revised: • 1st paragraph, 1st sentence: "Medicare Advantage and California Exchange products, and identifies…"
Home Infusion Therapy	HIT Providers and Infusion Pharmacies	• Revised subsection title formally known as: "Freestanding HIT Providers and Infusion Pharmacies"
Home Infusion Therapy	Billing Requirements	• Revised subsection title formally known as: "Special Billing Requirements" • 1st, 2nd paragraph removed along with bullets • Revised line item 1, "Home infusion Providers should always provide…"
Home Infusion Therapy	Drugs	• Revised 1st bullet: "Oral drugs, inhaled and…" • Removed 2nd bullet: "inhalant drugs"

Section	Subsection	Changes
Home Infusion Therapy		• Removed "Medical Specialty Pharmacy" subsection
Laboratory	Introduction	• Revised 1st paragraph: "This section outlines general billing guidelines for all Anthem Blue Cross commercial…"
Laboratory	General Billing Guidelines	• Revised line item, Valid coding: "For claims submitted to Anthem Blue Cross, valid…"
Physical, Occupational and Speech Therapy	Introduction	• Revised subsection: "This section outlines general billing guidelines for all Anthem Blue Cross commercial plan …"
Physical, Occupational and	Reimbursement	• Revised Chart, Anthem Blue Cross Behavioral Health Fax: 866-582-2287
Submitting Changes	Ancillary Professional Provider Changes	• Revised last paragraph fax: 818-234-2836
Submitting Changes	Behavioral Health Professional Provider Changes	• Revised subsection including Practice Update Form • Removed Notification Timeline and Provider Directory Updates • Revised Practice Profile Form subsection • Revised subsection Notification Requirements: "Submit all completed requests directly to Provider Database Management via email…"
Submitting Changes	Contact Information	Added: Email: ProviderDatabaseAnthem@anthem.com • Removed telephone number
Submitting Changes	Workers' Compensation Providers	• Added subsection
Reimbursement	How Payments are Determined	• Revised 2nd paragraph, 2nd sentence: "negotiated rate or a discount off the California Division…" • Added 3rd sentence: "Reimbursement for Workers' Compensation will not…" • Removed 7th paragraph subsection: "If you are not participating in the Anthem Blue Cross Select PPO network…"
Reimbursement		• Removed Third-party Liens

Section	Subsection	Changes
Reimbursement	Backup Withholding	• Revised: • 1st paragraph: "The Internal Revenue Service (IRS) requires that we withhold 28 percent of the Anthem Blue Cross allowable amount, less any benefit reductions, in tax, called Federal Backup Withholding…" • 2nd paragraph: "**The withhold amount is 28 percent of the Anthem Blue Cross PPO allowable…" • 4th paragraph: "Should you receive this solicitation, complete the W-9 form and promptly mail it to the 1099 Tax Reporting department…" Anthem, Inc. 1099 Tax Reporting 120 S. Via Merida, CAT201-C005 Thousand Oaks, CA 91362 • Last paragraph: "Should you have any questions, call the 1099 Tax Reporting department at 888-246-4893. You may contact the 1099 Tax Reporting…"
Reimbursement	Explanation of Benefits (EOB)	• Revised subsection: "Refunds," "Information appears in the "Refund" section when Anthem Blue Cross is refunding money…"
		Revised: • 2nd paragraph: "the telephone number listed on the overpayment…" • 3rd paragraph: "address listed on the overpayment recovery…" Removed: Federal Employee Program content Revised: • Line item 2: "Day 2-5…" • Line item 3: "Letter number two is sent for claims that have…" • Line item 4: "Day 45-49…" • Line item 5: "In cases where Anthem Blue Cross determines that deducting from claim…"

Section	Subsection	Changes
Reimbursement	Overpayment Recovery Procedure	Revised: Line item 6: "Final letter request is sent if no payment…" • Removed: "FEP Overpayment Recovery Letters that are samples…"
Reimbursement	Preventable Adverse Events (PAE) Policy	• Added subsection
Medical Management Programs	Definitions	• Revised subsection
Medical Management Programs	Utilization Management	Added: • 1st paragraph following "Program Overview": "Providers and Facilities agree to abide by the following Utilization Management (UM) Program…" • 2nd paragraph following "Pre-service Review": "Provider shall ensure those non-emergency admissions and certain…"
Medical Management Programs	Care Coordination Management	Added: • 1st paragraph: "Facility shall comply with all requests for medical information…"
Medical Management Programs	Observation Bed Policy	• Added subsection
Medical Management Programs	On-site Program	• Revised subsection
Medical Management Programs	Post-service Review	• Revised subsection
Medical Management Programs	Utilization Review Timeframes	• Added 1st paragraph: "Please see section below (Anthem Blue Cross Prescription Drug…" • Added 2nd paragraph, 2nd sentence: "If a Medicare Advantage pre-service request is deemed to be expedited, the…"
Medical Management Programs	Electronic Data Exchange	• Added subsection
Medical Management Programs	Out-of-network Referrals	• Added 2nd paragraph, last sentence: "Requests for out-of-network referrals must be made prior to services being rendered."

Section	Subsection	Changes
Medical Management Programs	AIM Specialty Health (AIM)	Subsection was formerly titled, "American Imaging Management® (AIM®)" • Revised 1st paragraph, 2nd second sentence: "Since November 2012, AIM has also administered Anthem's Sleep Study Program for home-based study and…" • 2nd paragraph, added last sentence: "Ordering Physicians must contact AIM to obtain a preauthorization for…" • 3rd paragraph "Noted:" added: "and Sleep Test/Study" • 8th paragraph, added content: "Online Sleep Study/Test requests: www.aimspecialtyhealth.com/gowebsleep • 15th paragraph, added, "Clinical guidelines can be accessed on AIM's home at www.aimspecialtyhealth.com or on the Anthem Blue Cross Website at anthem.com/ca, select…"
Medical Management Programs	AIM Specialty Health (AIM)	• Revised subsection title to: "AIM's Radiology Management and Sleep Program and OptiNet® Survey Tool" • 2nd paragraph, added words: "and sleep" • 3rd paragraph, 3rd and 4th sentence, added the word: "grouper"
Medical Management Programs	Anthem Blue Cross Prescription Drug Pre-service Review Process	• Revised subsection • Added 2nd paragraph: "Under SB 866, the Department of Insurance and the Department of Managed Health Care developed a…"
Medical Management Programs	Federal Employee Program (FEP) Guidelines	• Revised 2nd, 3rd, 4th & 5th paragraph • Revised line item 1: UM 800-860-2156
Medical Management Programs	Transition Assistance Program for PMG/IPA Closures or Terminations, Hospital Closures or Terminations, and Newly Covered Enrollees	• Removed 1st paragraph: "Exception: Newly covered enrollees previously covered by an Individual Plan are not eligible." • Revised 1st paragraph, 3rd sentence, "Completion of Covered Services may be provided at an in-network…"

Sections	Subsections	Changes
Medical Management Programs	Transition Assistance Program for PMG/IPA Closures or Terminations, Hospital Closures or Terminations, and Newly Covered Enrollees	• Revised 5th paragraph, 3rd sentence: "A determination will be made within two (2) business days from the…" • Removed 4th sentence in 5th paragraph: "Urgent requests will be decided within 72…"
Medical Management Programs	Integration Health Services	• Revised subsection
Medical Management Programs	Transplant Denials	Revised contact information for "Transplant Life Transitions Program": Anthem Blue Cross Transplant Life Transitions Program 13550 Triton Park Blvd Mail Point: OH0102-C639 Louisville, KY 40223
Medical Management Programs	Additional Requirements	• Added subsection
Covered Individual Grievances and Appeals	Introduction	• Revised last two paragraphs: "Anthem Blue Cross and some Anthem Blue Cross Life and Health plans require Covered Individuals to file an appeal or grievance with us no later…"
Quality Improvement	Quality Improvement Program Overview	• Revised subsection
Quality Improvement	Access and Availability of Care	• Added 2nd bullet: "Participate in an annual telephonic survey to assess physician office's compliance with appointment…" • Revised 6th bullet: "Assess the ratio of physicians and high-volume specialists per California ZIP code, using excel…" • Added 7th bullet: "Assess the availability of physicians and high-volume specialists, using GeoAccess…"

Sections	Subsections	Changes
Quality Improvement	Access and Availability of Care	• Added 2nd bullet: "Participate in an annual telephonic survey to assess physician office's compliance with appointment…" • Revised 6th bullet: "Assess the ratio of physicians and high-volume specialists per California ZIP code, using excel…" • Added 7th bullet: "Assess the availability of physicians and high-volume specialists, using GeoAccess…"
Quality Improvement	Behavioral Health and EAP Access and Availability of Care	• Added 4th bullet: "Assess the availability of Behavioral Health and EAP practitioners…"
Quality Improvement	Member Satisfaction/ Experience	• Added "Experience" to subsection title and content
Quality Improvement	Overview of CAHPS®	• Added subsection
Quality Improvement	Overview of HEDIS®	• Added subsection
Quality Improvement	Clinical Practice Guidelines	• Revised subsection
Quality Improvement	Preventive Health Guidelines	• Added subsection
Quality Improvement	Continuity and Coordination of Care	Revised: • 1st bullet: "Journey Forward program (developed by a collaborative among WellPoint, UCLA's Cancer Survivorship Center, the National Coalition for Cancer…" • 3rd bullet: "The Polypharmacy Program identifies Covered Individuals who have prescriptions in 10 or more…" • 4th bullet: "Surveys to Assess Coordination of Care. Blue Cross conducts a survey with PCPs regarding their satisfaction with the…"
Quality Improvement	Continuity and Coordination of Care	Added: • 5th bullet: "Comorbid Medical Behavioral Health Program. The primary goal of the program is to provide Members who have chronic medical conditions…"

Sections	Subsections	Changes
Quality Improvement	Continuity and Coordination of Care	Added: • 6th bullet: "Severe and Persistent Mental Illness (SPMI) Program. The primary goal of the Program is to provide Members who have chronic behavioral health conditions…" Revised: • 7th bullet: "Antidepressant Medication Management Program. In support of appropriate clinical practice, Anthem Blue Cross has this patient-focused intervention to promote…" Added: • 8th bullet: "Transition Assistance Program. Refer to the *Medical Management Programs* section in this Manual…"
Quality Improvement	Patient Safety	• Added the word "Facilities" to subsection
Quality Improvement	Performance Data	• Added subsection
Quality Improvement	Preventable Adverse Events Policy	• Moved subsection to the "Reimbursement" section of this Manual
Quality Improvement	Medical Record Standards	• Added 2nd paragraph: "Anthem Blue Cross Plans (the "Plans") recognize the importance of medical record…" • Revised 3rd paragraph: "Medical record audits/reviews are performed annually on a percentage of randomly chosen primary care Providers (PCPs) contracted…" • Revised "Chart Elements/Content and Clinical Documentation": "This section of the audit, which is completed for all reviews, monitors the quality of medical record documentation. The reviewer indicates Standard Met…"
Quality Improvement	Chart Criteria Guidelines	Revised: • Line item 6: "History and physical exam documentation identifies appropriate…"

Sections	Subsections	Changes
Quality Improvement	Chart Criteria Guidelines	Revised: • Line item 7: "Laboratory tests and other studies are ordered, as appropriate…" • Line item 8: "Documentation of Advance Directive/Living Will/Power of Attorney discussion (including copies of any executed documents) in a prominent …" • Line item 9: "Documentation of continuity and coordination of care between the PCP, specialty physician (including BH specialty…"
Quality Improvement	Better Communication, Better Care: Provider Tools to Care for Diverse Populations	• This information appears in the Rights and Responsibilities section of this Manual
Quality Improvement	AIM Specialty Health® (AIM®)	Added: • 1st and 2nd paragraph website www.americanimaging.net/safety
Quality Improvement	Legal and Administrative Requirements	• Added subsection
Quality Improvement	For More Information Regarding Our Quality Improvement Program	• Added subsection to replace QI Contacts subsection
Pharmacy Program and Guidelines	Prior Authorization of Pharmacy Benefits Process (Commercial)	Added: • 8th paragraph and all content following to the end of this subsection. "Under SB 866, the Department of Insurance and the Department of Managed Health Care developed a uniform Prior Authorization form and will implement SB 866 effective October 1, 2014 for fully-insured Members regardless of the state where…"
Pharmacy Program and Guidelines	Specialty Pharmacy Program	Added: • 2nd bullet, "Or visit the Download Forms Link at: https://www.anthem.com/ca/health-insurance/customer-care/forms-library" • 4th bullet: "The Covered Individual may also request their physician complete the specialty pharmacy Exception form and follow the…"

Sections	Subsections	Changes
Pharmacy Program and Guidelines	Medical Benefit Coverage	• Removed Home Infusion Therapy (HIT) Network
Workers' Compensation	Entire section	• Revised entire section
Product Summary	Entire section	Revised: • BlueCard® Program • Blue Cross Medicare Supplement Open Plans • Workers' Compensation Added: • Anthem Dual Advantage (HMO SNP) • Anthem Select Advantage (HMO) • Blue Cross Medicare Supplement Closed Plans Removed: • Blue Cross Senior AdvantageCare Plan • Blue Cross Senior Select and Senior Select Plus • Blue Cross Senior Classic Plans, Classic C, F, I and J • Blue Cross Senior Smart Choice Plan
Glossary	Glossary Terms	Revised: • Availity Web Portal (Availity) • Blue Cross Blue Shield Association (The Association) • Parity Benefits • ProviderAccess® • Provider Data Management (PDM)
360° Health®	Targeted Individualized Interventions	• Revised 1st paragraph • Added last bullet: "Ancillary Healthcare Professional consultations"
Medical Policy	Entire Section	• Revised entire section
Medicare Crossover	Entire Section	• Added section in 2015

Sections	Subsections	Changes
Anthem Centers of Medical Excellence	Centers of Medical Excellence	• Added subsection…. o Transplant o Cardiac Care o Bariatric Surgery o Complex and Rare Cancers o Spine Surgery o Knee and Hip Replacement
Dispute Resolution Process for Contracted Providers	Dispute Resolution Process for Contracted Providers	Revised: • Line item 2: "Secure Messaging – Availity Web Portal (Availity) The Availity Web Portal provided the…" • Line item 5: "Acknowledgment of Contracted Provider Disputes. Anthem Blue Cross will acknowledge…"
Links	Entire Section	Added: • Behavioral Health provider Resources • Centers of Medical Excellence • Health Insurance Exchange
Audit	Entire Section	• Revised entire section • Added in 2015: "Pre-payment Review Policy"
Health Insurance Market Exchange	Entire Section	• Added in 2015
Exhibits	Entire Section	Added: • Advance Patient Notice Form • Coordination of Care Form • Cover Letter for Behavioral Health Practitioners • Cover Letter for Medical

Sections	Subsections	Changes
Exhibits	Entire Section	Revised: • Anthem Centers of Medical Excellence Manual • Continuity of Care/Transition of Care Request Form • Covered Individual (Patient) Responsibility Agreement – Waiver • Blue Cross Blue Shield Federal Employee Program • Blue Cross POS • Blue Cross PPO • Medicare Preferred PPO • Select PPO • Individual Authorization for Release of Protected Health Information Form • Manual Search Tool • Practice Profile • Practice Update Form • Provider Dispute Resolution Request • Request for Prudent Buyer Plan Pricing
Exhibits	Entire Section	Removed: • A Guide to Sexual History Taking • BlueCard Contact List • Claim Re-process Form • FEP Overpayment Recovery Letter #1 • FEP Overpayment Recovery Letter #2 • FEP Overpayment Recovery Letter #3 • FEP Overpayment Recovery Letter #4 • Patient-administered Sexual History Questionnaire • Preventive Health Guidelines • Psychotherapy Notes Authorization
Appendix A – Affiliates List	Entire Section	Current list dated October 1, 2014
Appendix C – Notice of Privacy Practices	Entire Section	Current notice Effective January 1, 2015

Advance Patient Notice Form

Your physician is referring you to a non-participating physician or other type of provider for certain healthcare services. You have the right to receive services at a participating provider in order to obtain full benefits under your health coverage. If you have questions or would like to locate an in-network provider, please contact Anthem Blue Cross Customer Service at the telephone number listed on the back of your identification card.

To be completed by the referring physician:	
Please check the type of referral (check all that apply): □ Non-Par Physician or Other Provider □ Non-Par Facility □ Both	
Referring Physician Name:	**NPI #:**
Patient Name:	**Member ID#:**
Non-Participating Physician/Provider Name:	**Specialty:**
Non-Participating Facility Name:	**Type of Facility:**
Reason for non-par referral:	**Date of Service:**

To be completed by the patient or patient's legal guardian:

My signature below means that I have read and understood the following:

1. The healthcare provider named above does not participate with Anthem Blue Cross.
2. I may be responsible for extra costs if I get services from this provider.
3. I can call Anthem Blue Cross before getting services to confirm my benefits. I can call Anthem Blue Cross to get names of participating providers that can provide the recommended services.
4. This provider will collect co-payments, deductibles, coinsurance or other amounts I am required to pay under my benefit plan.
5. I am voluntarily choosing on behalf of myself or the patient named above to get services from this provider.

Signature of Patient, Parent (if patient under age 18) or Legal Guardian:	
Printed name of Patient, Parent (if patient under age 18) or Legal Guardian:	
Date:	**Daytime Phone Number:**

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Anthem Centers of Medical Excellence (CME)
Transplant Network

CONTRACT OPERATIONS MANUAL
for

A supplemental document to the Anthem Blue Cross Professional Manual

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APPENDIX A **18**

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 General Service 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, 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".

For the Purposes of the Anthem Blue Cross Professional Manual, The following list 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 (includes products such as: Traditional)
Anthem Blue Cross Senior Secure

[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 General Service 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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ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION II

QUALITY OVERSIGHT OF THE ANTHEM BLUE CROSS CME TRANSPLANT NETWORK

The **Anthem Centers of Medical Excellence** (**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 Provider Network Manager (contract manager) and express your interest. Anthem Blue Cross Provider Network Manager will notify the Anthem Blue Cross 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 Centers of Medical Excellence (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	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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ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION II

QUALITY OVERSIGHT OF THE ANTHEM BLUE CROSS CME TRANSPLANT 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 Member Grievance and Appeal Section and Utilization Management Programs Section.

Appeal Process
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 reconsidered 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
GAG008-0004
Atlanta, GA. 30326

Provider Responsibility
As a participation provider in the **Anthem Centers of Medical Excellence** (**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. All health care professionals are required to refer patients to an **Anthem Blue Cross** approved facility, unless there is a medical reason for referring the patient to a non-approved transplant facility.

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TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION III

TRANSPLANT LIFE TRANSITIONS 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:
Ph: 1-888-574-7215
Fax: 866-255-2471

To Contact the Member's Transplant Case Manager:
Ph: 1-888-574-7215
Fax: 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 Utilization Management Programs Section of the BCC 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 Blue Cross** a request for transplant authorization and the Covered Individual's clinical records to support this request. **Anthem Blue Cross** 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 the transplant case manager at the phone number listed in Section III above. 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 **via the National Marrow Donor Program (simple sibling/member HLA typing is exempt from review)**

Marrow/stem cell harvesting collection, modification and/or storage
Donor Leukocyte Infusions
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

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information is required to authorize the requested procedure. Note all clinical information and diagnostic tests submitted must be current, within one year of the request. Once medical necessity is established, authorization letters are sent to the transplant physician, CME facility and the member. The transplant department may issue a Clinical Data Submission Tool to obtain necessary information to complete the review for Medical Necessity of the requested transplant.

When admission for transplant occurs, the CME facility contacts the assigned transplant case manager for ongoing case management.

Re-certification. As long as the member is active with the health plan and actively listed with UNOS, no re-certification s needed. Benefits and eligibility will be checked and verified annually.

Continued Stay Coordination. 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.)

Appeal Process
Please refer to Members Appeals and Grievance Process in the Anthem Blue Cross Provider Manual.

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ANTHEM CENTERS OF MEDICAL EXCELLENCE
TRANSPLANT CONTRACT OPERATIONS MANUAL

SECTION IV

ANTHEM CENTERS OF MEDICAL EXCELLENCE (CME) TRANSPLANT CLAIM BILLING GUIDELINES

Anthem CME Transplant Claim Billing Guidelines and Claim Submission Requirements

Please refer to the Anthem Blue Cross Professional Manual for billing instructions for non-transplant related claims.

Send Bundled Hard Copy [Cell 3] 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 89508
Attention: Sabrina Ausum
513-872-3853

Colorado, Nevada

Submit all Global Claims except FEP to:
Denise Scull
700 Broadway - **Mail Stop CO0107-042**
Denver, CO 80203
303-831-2701 Fax: 303-764-7131
E-mail: Denise.Scull@anthem.com

FEP Colorado, Nevada

Submit FEP Global Claims to:
Tekelah Bruce
Anthem Blue Cross and Blue Shield
220 Virginia Ave - **Mail Stop IN0204-B576**
Indianapolis, IN 46204
317-287-2945 Fax: 317-287-2324
E-mail: Tekelah.Bruce@anthem.com

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Connecticut, Maine, New Hampshire

Submit all Global Claims except FEP to:
Diane Therrien
Anthem Blue Cross and Blue Shield of Connecticut
Prepayment Review-High Dollar Claim Dept.
108 Leigus Road - **Mail Stop CT112D-4083**
Wallingford, CT 06492
203-634-6602 Fax: 203-634-6602
E-mail: Diane.Therrien@anthem.com

FEP Connecticut, Maine, New Hampshire

Submit FEP Global Claims to:
Christina J. Robinson
Anthem Blue Cross and Blue Shield
602 S. Jefferson Street
Roanoke, VA 24011
540-853.3107 Fax: 540-853-3445
E-mail: Christina.Robinson@anthem.com

Georgia

Submit all Global Claims including FEP to:
Lacy Long
Blue Cross and Blue Shield of Georgia
2357 Warm Springs Road - **Mail Stop GAG301-0003**
Columbus, GA 31904-5668
706-985-2347
E-mail: Lacy.Long@bcbsga.com

Indiana, Kentucky, Ohio, Missouri, Wisconsin

Submit all Global Claims except FEP to:
Linda Bueker
Anthem Blue Cross and Blue Shield
4241 Irwin Simpson Rd
Transplant Unit - **Mail Stop OH0203-700**
Mason, OH 45040
513-336-4799 Fax: 513-336-5508
E-mail: Linda.Bueker@anthem.com

FEP Missouri HMO

Submit FEP Global Claims to:
Linda Bueker
Anthem Blue Cross and Blue Shield
4241 Irwin Simpson Rd
Transplant Unit - **Mail Stop OH0203-700**
Mason, OH 45040
513-336-4799 Fax: 513-336-5508
E-mail: Linda.Bueker@anthem.com

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FEP Indiana (all claims), Kentucky (all claims), Ohio (all claims), Missouri FEP PPO, Wisconsin (all claims)

Submit FEP Global Claims to:
Danielle Robbins
Anthem Blue Cross and Blue Shield
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:
Filomena Mastria
Empire Blue Cross and Blue Shield
85 Crystal Run Rd. Middleton, NY 10940
Fax: 845-695-4337
E-mail: Filomena.Mastria@anthem.com

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: NY0R3C-9999**
Middletown, NY 10940
518-367-4461 Fax: 518-367-6124
E-mail: Stacey.Davis@anthem.com

Virginia

Submit all Global Claims to:
Renee Gilbert
Anthem Blue Cross and Blue Shield of Virginia
1514 John Jones Road
Bahama, NC 27503
919-477-3691 Fax: 919-477-2892
E-mail: Renee.Gilbert@anthem.com

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FEP Virginia

Submit all FEP Global Claims to:

Renee Gilbert
Anthem Blue Cross and Blue Shield of Virginia
1514 John Jones Road
Bahama, NC 27503
919-477-3691 Fax: 919-477-2892
E-mail: Renee.Gilbert@anthem.com

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ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

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.

Description of the Four Transplant Cells
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 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).

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Continued

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 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

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ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

Cell 3 Exclusions:
If there are any exclusion to Cell 1, 3 or 4 add here.

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.

General Global Billing Guidelines for the Four Transplant Cells

Cell 1 Processing Guidelines (if applicable)
Processed in accordance with the Anthem Local Agreement

Cell 2 Processing Guidelines (if applicable)
Processed in accordance with the Anthem Local 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 HCFA 1500 claim forms) for all inpatient and outpatient-Hospital, Professional, and Ancillary charges included in the Global Case Rate, and outlier rate (if applicable).

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. Form A should be included with solid organ transplant bundled claims.

Cell 4 Processing Guidelines (if applicable)
Processed in accordance with the Anthem Local Agreement and Anthem Physician Fee Schedule.

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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Continued

Global Case Rate Period 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 HCFA 1500 claim forms) for all inpatient and outpatient-Hospital, Professional, and Ancillary charges included in the Global Case Rate, (if applicable). **Professional and Facility Claims will be bundled in separate packets and include with Form D. Stoploss is calculated separately with separate reimbursement for Facility and for Professional.** 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 except if included in the Global Case Rate.
- Charges after the Global Case Rate Period for Transplant.

Mail the bundled Global Case Rate Period claim packet with the proper Billing Summary Form (See Appendix A) in one envelope to the claim address listed below. Failure to include the Billing Summary Form may result in delayed correct payment

Questions Regarding Claim Payment:
Refer to the Directory of Payment link under the Claims Submission Section of the Anthem Blue Cross Facility Operations Manual

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.

Transplant services for non-**Anthem Blue Cross** Covered Individuals utilizing the BlueCard system should be submitted in the same manner as non-transplant claims

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-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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ANTHEM CME TRANSPLANT CLAIM BILLING GUIDELINES
Continued

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. Benefits could be processed at different benefit levels based on the contract.

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.

Sample Coding (not all inclusive, samples only):
Solid Organ

Transplant Type	CPT Code	ICD-9 Code ***For dates of service prior to 10/01/2014***	ICD-10 Code ***For dates of service on or after 10/01/2014***
Heart	33945 Heart transplant, with or without recipient cardiectomy	37.51 Heart transplantation	02YA0Z0 Transplantation of heart, allogeneic, open approach
Lung	32851 Lung transplant, single; without cardiopulmonary bypass	33.51 Unilateral lung transplantation	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	50.5 Liver transplant	0FY00Z0 Transplantation of liver, allogeneic, open approach
Kidney	50360 Renal allotransplantation, implantation of graft; without recipient nephrectomy	55.69 Other kidney transplantation	0TY00Z0 Transplantation of right kidney, allogeneic, open approach
Pancreas	48554 Transplantation of pancreatic allograft	52.80 Pancreatic transplant, not otherwise specified	0FYG0Z0 Transplantation of pancreas, allogeneic, open approach
Organ Acquisition	810-819		

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Sample BMT/Stem Cell Coding:

Transplant Type	CPT Code	ICD-9 Code ***For dates of service prior to 10/01/2014***	ICD-10 Code ***For dates of service on or after 10/01/2014***
Autologous	38206 Blood-derived hematopoietic progenitor cell harvesting autologous		
	38232 Bone marrow harvesting for transplantation; autologous		
	38241 Hematopoietic progenitor cell (HPC); autologous transplantation	41.01 Autologous bone marrow transplant without purging	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		
		41.03 Allogeneic bone marrow transplant without purging	30230G1-30263G1 Transfusion of nonautologous bone marrow
		41.05 Allogeneic hematopoietic stem cell transplant without purging	30230Y1-30263Y1 Transfusion of nonautologous hematopoietic stem cells [by site and approach
		41.06 Cord blood stem cell transplant	30230X1-30263X1 Transfusion of nonautologous cord blood stem cells [by site and approach

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APPENDIX A

FORM A HOSPITAL NOTIFICATION FORM

FORM B PATIENT DISCHARGE FORM

FORM C SOLID ORGAN BILLING SUMMARY FORM

FORM D BONE MARROW/STEM CELL

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FORM A

HOSPITAL NOTIFICATION OF TRANSPLANT ADMISSION FORM

Date _____ FEP Member ☐ Non FEP Member ☐

Non FEP Member
To: Transplant Claim Unit Fax #: 877-264-7215
Phone #: 800-574-7215

FEP Member
To: FEP Transplant Unit outside of California Fax #: 866-255-2471
Phone # **800-824-0581 Press 1**

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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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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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:
*$*_____

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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FORM D BILLING SUMMARY FORM
BONE MARROW/STEM CELLTRANSPLANT

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, ie, 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 CaseRate(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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Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved OMB
No. 0938-0950

Appointment of Representative

Name of Party	Medicare or National Provider Identifier Number

Section 1: Appointment of Representative

To be completed by the party seeking representation (i.e., the Medicare beneficiary, the provider or the supplier):

I appoint this individual, _____ to act as my representative in connection with my claim or asserted right under title XVIII of the Social Security Act (the "Act") and related provisions of title XI of the Act. I authorize this individual to make any request; to present or to elicit evidence; to obtain appeals information; and to receive any notice in connection with my appeal, wholly in my stead. I understand that personal medical information related to my appeal may be disclosed to the representative indicated below.

Signature of Party Seeking Representation		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 2: Acceptance of Appointment

To be completed by the representative:

I, _____, hereby accept the above appointment. I certify that I have not been disqualified, suspended, or prohibited from practice before the department of Health and Human Services; that I am not, as a current or former employee of the United States, disqualified from acting as the party's representative; and that I recognize that any fee may be subject to review and approval by the Secretary.

I am a / an _____
(Professional status or relationship to the party, e.g. attorney, relative, etc.)

Signature of Representative		Date
Street Address		Phone Number (with Area Code)
City	State	Zip Code

Section 3: Waiver of Fee for Representation

Instructions: This section must be completed if the representative is required to, or chooses to waive their fee for representation. (Note that providers or suppliers that are representing a beneficiary and furnished the items or services may not charge a fee for representation and **must** complete this section.)

I waive my right to charge and collect a fee for representing _____ before the Secretary of the Department of Health and Human Services.

Signature	Date

Section 4: Waiver of Payment for Items or Services at Issue

Instructions: Providers or suppliers serving as a representative for a beneficiary to whom they provided items or services must complete this section if the appeal involves a question of liability under section 1879(a)(2) of the Act. (Section 1879(a)(2) generally addresses whether a provider/supplier or beneficiary did not know, or could not reasonably be expected to know, that the items or services at issue would not be covered by Medicare.)

I waive my right to collect payment from the beneficiary for the items or services at issue in this appeal if a determination of liability under §1879(a)(2) of the Act is at issue.

Signature	Date

Charging of Fees for Representing Beneficiaries Before the Secretary of the Department of Health and Human Services

An attorney, or other representative for a beneficiary, who wishes to charge a fee for services rendered in connection with an appeal before the Secretary of the Department of Health and Human Services (DHHS) (i.e., an Administrative Law Judge (ALJ) hearing, Medicare Appeals Council review, or a proceeding before an ALJ or the Medicare Appeals Council as a result of a remand from federal district court) is required to obtain approval of the fee in accordance with 42 CFR §405.910(f).

The form, "Petition to Obtain Representative Fee" elicits the information required for a fee petition. It should be completed by the representative and filed with the request for ALJ hearing or request for Medicare Appeals Council review.

Approval of a representative's fee is not required if: (1) the appellant being represented is a provider or supplier; (2) the fee is for services rendered in an official capacity such as that of legal guardian, committee, or similar court appointed representative and the court has approved the fee in question; (3) the fee is for representation of a beneficiary in a proceeding in federal district court; or (4) the fee is for representation of a beneficiary in a redetermination or reconsideration. If the representative wishes to waive a fee, he or she may do so. Section III on the front of this form can be used for that purpose. In some instances, as indicated on the form, the fee must be waived for representation

Authorization of Fee

The requirement for the approval of fees ensures that a representative will receive fair value for the services performed before DHHS on behalf of a beneficiary, and provides the beneficiary with a measure of security that the fees are determined to be reasonable. In approving a requested fee, the ALJ or Medicare Appeals Council will consider the nature and type of services rendered, the complexity of the case, the level of skill and competence required in rendition of the services, the amount of time spent on the case, the results achieved, the level of administrative review to which the representative carried the appeal and the amount of the fee requested by the representative.

Conflict of Interest

Sections 203, 205 and 207 of title XVIII of the United States Code make It a crlmlnal offense for certain officers, employees and former officers and employees of the United States to render certain services in matters affecting the Government or to aid or assist in the prosecution of claims against the United States. Individuals with a conflict of interest are excluded from being representatives of beneficiaries before DHHS.

Where to Send This Form

Send this form to the same location where you are sending (or have already sent): (1) your appeal if you are filing an appeal, (2) grievance if you are filing a grievance, or (3) initial determination or decision if you are requesting an initial determination or decision.

If addltlonal help is needed, contact your Medicare plan or 1-800-MEDICARE (1-800-633-4227).

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB contrcl number for this information collection is 0938-0950. The time required to prepare and distribute this collection is 15 minutes per notice, including the time to select the preprinted form, complete it and deliver it to the beneficiary. If you have comments concerning the accuracy of the time estimates or suggestions for improving this form, please write to CMS, PRA Clearance Officer, 7500 Security Boulevard, Baltimore, Maryland 21244-1850.

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 in an Anthem Blue Cross plan (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 Customer Care.

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 Customer Care Number on the back of your Anthem Blue Cross card or the Customer Care 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

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Continuity of Care / Transition of Care Request Form

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.*

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 POS PPO EPO CDHP OTHER

New Anthem Blue Cross Plan: HMO 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 03/06/14

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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 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 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:

Continuity of Care: Application New Enrollee and Application Network Disruptions consolidated herein. Last revised 03/06/14

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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
- ☐ Chronic Illness
- ☐ Medication Management
- ☐ Routine Care
- ☐ Substance Abuse
- ☐ Change in Medical Status
- ☐ Eating Disorder
- ☐ Other Mental Health Issues _____

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 Diagnosis. 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 Diagnosis. 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

ANTHEM BLUE CROSS

COVERED INDIVIDUAL (PATIENT) RESPONSIBILITY AGREEMENT – WAIVER FORM

Contracting Anthem Blue Cross health care professionals/facilities ("Providers") are prohibited from charging Anthem Blue Cross Covered Individuals for any service or supply that is determined by Anthem Blue Cross to be not medically necessary or non-covered, unless the Covered Individuals specifically agrees in advance of the provision of the service or supply to be financially responsible for it. 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 Covered Individual'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.

COVERED INDIVIDUAL (PATIENT) NAME:_____ DOB:_____

SUBSCRIBER ID:_____GROUP NO.:_____

PROVIDER: _____

PROVIDER NPI/TAXID: _____

PROVIDER PHONE: _____

COVERED INDIVIDUAL:

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 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	Covered Individual's (Patient's) Responsibility

Signature:_____ Date: _____

Covered Individual/ Subscriber Signature

PROVIDER:

Provider please send a completed copy of this waiver form with the initial claim to the claims address on the Covered Individual (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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91470-0001

EOB SAMPLE

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
February 6, 2011	0001 OF 0007

BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: ALBERTS MARY ID Number: 958A01683 Account Number: ALBERTS90 Group Number: A789QA
Claim ID: 10337213261 Claim Received Date: 12/02/10 ANTHEM BLUE CROSS AGREEMENT

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/02/10	71250	001	200.00	200.00	0.00	0.00	60.00 /01	140.00
TOTAL THIS CLAIM			200.00	200.00	0.00	0.00	60.00	# 140.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-877-216-3980

Patient Name: ALBERTS JOHN ID Number: 958A01683 Account Number: ALBERTSJ4 Group Number: A789QA
Claim ID: 10337213262 Claim Received Date: 12/02/10

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/03/10	99221	001	-150.00	-73.66	-76.34	0.00	-14.73	-58.93
TOTAL THIS CLAIM			-150.00	-73.66	-76.34	0.00	-14.73	-58.93

Patient Name: ALBERTS JOHN ID Number: 958A01683 Account Number: ALBERTSJ5 Group Number: A789QA
Claim ID: 10337213262 Claim Received Date: 12/01/10 ANTHEM BLUE CROSS AGREEMENT

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/03/10	99221	001	150.00	73.66	76.34 /02	0.00	22.10 /01	51.56
TOTAL THIS CLAIM			150.00	73.66	76.34	0.00	22.10	51.56

This is an adjustment to a previously processed claim, refer to EOB Sequence no.: 948765432 201100004

FOR INFORMATION CALL: 1-877-216-3980

Patient Name: ALBERTS JOHN ID Number: 958A01683 Account Number: ALBERTSJ6 Group Number: A789QA
Claim ID: 10337213263 Claim Received Date: 12/02/10 ANTHEM BLUE CROSS AGREEMENT

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/04/10	77280	001	85.00	85.00	0.00	0.00	25.50 /01	59.50
TOTAL THIS CLAIM			85.00	85.00	0.00	0.00	25.50	59.50

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-877-216-3980

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BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: REYES GERARDO ID Number: 900A13815 Account Number: REYESG020 Group Number: 1271CA
Claim ID: 11018597671 Claim Received Date: 01/18/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
01/10/11	70470	001	-100.00	-70.81	-29.19	0.00	0.00	-70.81
01/10/11	99213	001	-50.00	-50.00	0.00	0.00	0.00	-50.00
	TOTAL THIS CLAIM		-150.00	-120.81	-29.19	0.00	0.00	-120.81

Patient Name: REYES GERARDO ID Number: 900A13815 Account Number: REYESG020 Group Number: 1271CA
Claim ID: 11018597671 Claim Received Date: 01/18/11 ANTHEM BLUE CROSS AGREEMENT

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
01/10/11	70470	001	100.00	70.81	100.00 /02			0.00
01/10/11	99213	001	50.00	50.00	50.00 /02			0.00
	TOTAL THIS CLAIM		150.00	120.81	150.00	0.00	0.00	0.00

This is an adjustment to a previously processed claim, refer to EOB Sequence no.: 948765432 201100009

FOR INFORMATION CALL: 1-800-845-3604

Patient Name: SMILEY LINDA ID Number: 111A19295 Account Number: SMILEYL07 Group Number: 00149A
Claim ID: 11028240000 Claim Received Date: 01/28/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
01/16/11	99214	001	-150.00	-59.59	-90.41 /02	0.00	-29.80 /01	-29.79
01/16/11	99199	001	-25.00	-25.00	0.00	0.00	-12.50 /01	-12.50
01/16/11	77402	001	-75.00	-75.00	0.00	0.00	-37.50 /01	-37.50
	TOTAL THIS CLAIM		-250.00	-159.59	-90.41	0.00	-79.80	-79.79

Patient Name: SMILEY LINDA ID Number: 111A19295 Account Number: SMILEYL07 Group Number: 00149A
Claim ID: 11028240000 Claim Received Date: 01/28/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
01/16/11	99214	001	150.00	59.59	90.41 /02	0.00	29.80 /01	29.79
01/16/11	99199	001	25.00	25.00	0.00	0.00	25.00 /05	0.00
01/16/11	77402	001	75.00	75.00	0.00	0.00	37.50 /01	37.50
	TOTAL THIS CLAIM		250.00	159.59	90.41	0.00	92.30	67.29

This is an adjustment to a previously processed claim, refer to EOB Sequence no.: 948765432 201100009 FOR INFORMATION CALL: 1-800-845-3604

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BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: ALBERTS MARY ID Number: 958A01683 Account Number: ALBERTSM9 Group Number: A789QA
Claim ID: 10337213264 Claim Received Date: 12/02/10

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/05/10	71250	001	-80.00	-80.00	0.00	0.00	-16.00 /01	-64.00
TOTAL THIS CLAIM			-80.00	-80.00	0.00	0.00	-16.00	-64.00

Patient Name: ALBERTS MARY ID Number: 958A01683 Account Number: ALBERTSM9 Group Number: A789QA
Claim ID: 10337213264 Claim Received Date: 12/02/10 ANTHEM BLUE CROSS AGREEMENT

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
10/05/10	71250	001	80.00	80.00			24.00 /01	56.00
TOTAL THIS CLAIM			80.00	80.00	0.00	0.00	24.00	56.00

This is an adjustment to a previously processed claim, refer to EOB Sequence No.: 948765432 201100004

FOR INFORMATION CALL: 1-877-216-3980

Patient Name: FOX ADAM II ID Number: 079A05328 Account Number: FOXA0440 Group Number: 00076A
Claim ID: 10362162504 Claim Received Date: 12/27/10

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
11/09/10	77402	001	100.00	100.00	0.00	0.00	20.00 /01	80.00
11/10/10	77402	001	100.00	100.00	0.00	0.00	20.00 /01	80.00
11/11/10	77402	001	100.00	100.00	0.00	0.00	20.00 /01	80.00
TOTAL THIS CLAIM			300.00	300.00	0.00	0.00	60.00	240.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-800-888-8288

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EOB SAMPLE

EXPLANATION OF BENEFITS

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BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: FOX ADAM ID Number: 079A05328 Account Number: FOXA0444 Group Number: 00076A
Claim ID: 10350162507 Claim Received Date: 12/15/10

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
11/30/10	77402	001	100.00	100.00	0.00	0.00	20.00 /01	80.00
TOTAL THIS CLAIM			100.00	100.00	0.00	0.00	20.00	80.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-800-888-8288

Patient Name: BOONE DIANE ID Number: 556A70395 Account Number: BONNED60 Group Number: P8045C
Claim ID: 10024240005 Claim Received Date:

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/17/10	99199	001	-50.00	0.00	-50.00	0.00	0.00	0.00
12/17/10	99213	001	-50.00	0.00	-50.00	0.00	0.00	0.00
12/17/10	77402	001	-50.00	-50.00	0.00	0.00	-20.00	-30.00
TOTAL THIS CLAIM			-150.00	-50.00	-100.00	0.00	-20.00	-30.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-800-888-8288

Patient Name: BOONE DIANE ID Number: 556A70395 Account Number: BOONED60 Group Number: P8045C
Claim ID: 10024240005 Claim Received Date: 01/24/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/17/10	99199	001	50.00	50.00	0.00	50.00 /04	0.00	0.00
12/17/10	99213	001	50.00	50.00	0.00	50.00 /04	0.00	0.00
12/17/10	77402	001	50.00	50.00	0.00	0.00	30.00 /01	20.00
TOTAL THIS CLAIM			100.00	100.00	0.00	100.00	30.00	20.00

This is an adjustment to a previously processed claim, refer to Sequence Number 948765432 201100002

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91470-0001

EOB SAMPLE

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
February 6, 2011	5 OF 0007

BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: BERGER WILLIAM ID Number: 548A58503 Account Number: BERGERW9 Group Number: 08025C
Claim ID: 11033684000 Claim Received Date: 02/02/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/04/10	20830	045	-1,000.00	-246.08	-753.92	0.00	0.00	-246.08
TOTAL THIS CLAIM			-1,000.00	-246.08	-753.92	0.00	0.00	-246.08

Administered on behalf of BC life & Health Insurance Company

Patient Name: BERGER WILLIAM ID Number: 548A58503 Account Number: BERGERW9 Group Number: 08025C
Claim ID: 11033684000 Claim Received Date: 02/02/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/04/10	830	045	1,000.00	600.00	400.00 /02	0.00	0.00	600.00
TOTAL THIS CLAIM			1,000.00	600.00	400.00	0.00	0.00	600.00

This is an adjustment to a previously processed claim, refer to Sequence No. 948765432 200800010

Patient Name: ROSAS ERICA ID Number: 903A4083C Account Number: ROSASE022 Group Number: 1270KA
Claim ID: 10365601121 Claim Received Date: 12/31/10 ANTHEM BLUE CROSS MEDI-CAL

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/22/10	99214	001	-110.00	-62.12	-110 /06	0.00	0.00	0.00
12/22/10	59025	001	-120.00	-27.36	-120.00 /06	0.00	0.00	0.00
12/22/10	81003	001	-15.00	-3.40	-15.00 /06	0.00	0.00	0.00
TOTAL THIS CLAIM			-245.00	-92.88	-245.00	0.00	0.00	0.00

Patient Name: ROSAS ERICA ID Number: 903A4083C Account Number: ROSASE022 Group Number: 1270KA
Claim ID: 10365601121 Claim Received Date: 12/31/10

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
12/22/10	99214	001	110.00	0.00	110.00 /06	0.00	0.00	0.00
12/22/10	59025	001	120.00	0.00	120.00 /06	0.00	0.00	0.00
12/22/10	81003	001	15.00	0.00	15.00 /06	0.00	0.00	0.00
TOTAL THIS CLAIM			245.00	0.00	245.00	0.00	0.00	0.00

This is an adjustment to a previously processed claim, refer to EOB Sequence no.: 948765432 201100154 FOR INFORMATION CALL: 1-800-845-3604

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EOB SAMPLE

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
February 6, 2011	6 OF 0007

BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER: 948765432 201100012

Provider ID: 948765432

NETWORK PROVIDER: Y

FOUNDATION PHYSICIAN: N

Patient Name: SMITH SAM ID Number: 700A63002 Account Number: SMITHS0026 Group Number: 00746A
Claim ID: 1102324000 Claim Received Date: 01/23/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
11/15/10	96201	001	150.00	59.59	90.41	0.00	59.59 /01	0.00
11/15/10	99214	001	150.00	90.00	60.00	0.00	90.00 /01	0.00
TOTAL THIS CLAIM			300.00	149.59	150.41	0.00	149.59	0.00

Administered on behalf of BC Life & Health Insurance Company FOR INFORMATION CALL: 1-800-888-8288

Patient Name: ALDO TESSA ID Number: 111A24192 Account Number: ALDOT7460 Group Number: 00149A
Claim ID: 11016240001 Claim Received Date: 01/16/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COINSURANCE COPAYMENT AMOUNT	CLAIMS PAYMENT
11/15/10	99215	001	-150.00	0.00	0.00	-150.00 /04	0.00	0.00
11/15/10	44604	001	-300.00	0.00	0.00	-137.58 /04	-48.73 /01	-113.69
11/15/10	85025	001	-50.00	0.00	0.00	0.00	-15.00 /05	-35.00
TOTAL THIS CLAIM			-500.00	0.00	0.00	-287.58	-63.73	-148.69

Patient Name: ALDO TESSA ID Number: 111A24192 Account Number: ALDOT7460 Group Number: 00149A
Claim ID: 11016240001 Claim Received Date: 01/16/11

SERVICE DATE(s)	PROCEDURE NUMBER	UNITS OF SERVICE	BILLED AMOUNT	ALLOWED AMOUNT	NOT ALLOWED AMOUNT	DEDUCTIBLE AMOUNT	COPAYMENT AMOUNT	CLAIMS PAYMENT
11/15/10	99215	001	150.00	140.28	9.72 /02	0.00	42.08 /01	98.20
11/15/10	44604	001	300.00	220.00	80.00 /02	0.00	30.00 /01	190.00
11/15/10	85025	001	50.00	20.00	30.00 /02	0.00	20.00 /05	0.00
TOTAL THIS CLAIM			500.00	380.28	119.72	0.00	92.08	288.20

This is an adjustment to a previously processed claim, refer to Sequence Number 948765432 201100383

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EOB SAMPLE

EXPLANATION OF BENEFITS

ISSUE DATE	PAGE
February 6, 2011	0007 OF 0007

BCC URGENT CARE
45678 Topanga Cyn Blvd.
WOODLAND HILLS, CA 91367

SEQUENCE NUMBER:	**948765432**	**201100012**
Provider ID:	**948765432**	
NETWORK PROVIDER:	**Y**	
FOUNDATION PHYSICIAN:	**N**	

* Administered by Anthem Blue Cross on behalf of Blue Cross Life & Health Insurance Company

MESSAGES:

1 - This balance is the member's coinsurance responsibility.
2 - This is the amount in excess of the allowed expense for a participating provider. The member, therefore, is not responsible for this amount.
3 - This is a duplicate claim. Status of the original claim is available for review on the website. If access to the internet is not available, please contact the Customer Service number located on the back of the member's ID card.
4 - This is the amount that has been applied to the member's medical deductible.
05 - This is the member's co-payment responsibility.
06 - This is not a covered benefit of the member's plan and this amount, therefore, is the responsibility of the member.
Statutory interest included for delayed payment.
* - Anthem Blue Cross encourages and supports the submission of electronic transactions. For information regarding electronic transactions, please contact EDI Services at anthem.com/ca.

PAYMENT SUMMARY

CLAIMS PAYMENT/ ADJUSTMENTS	PROCESSED	PAID AMOUNT
Total Claims	519.50	519.50
Adjustments Payable Provider	493.43	493.43
Deferred Adjustments Due	-158.68	0.00
Sub Total		$1,012.93

STATUTORY INTEREST ON DELAYED PAYMENT

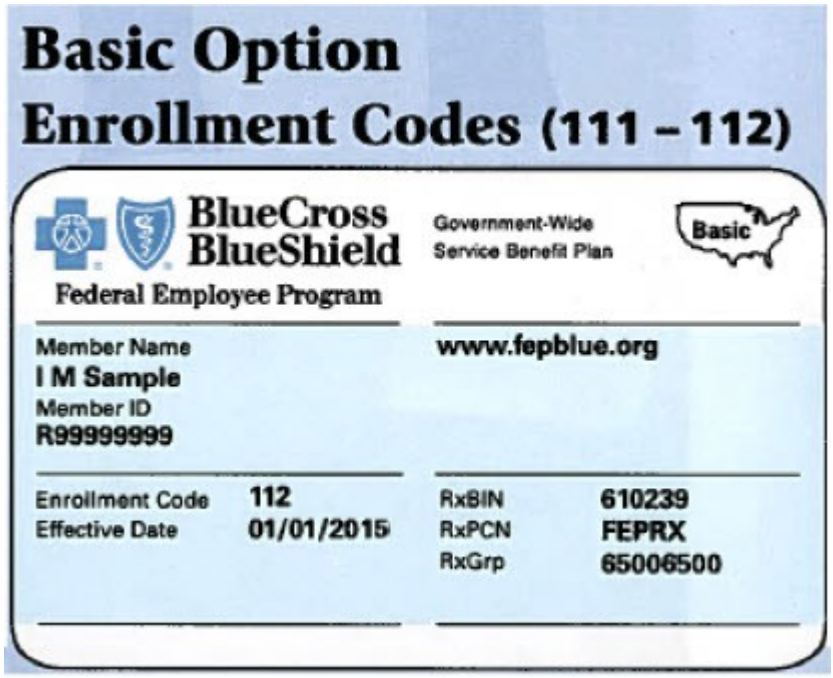
ALBERTS MARY	956A01683	10337213261	0.35

CHECK AMOUNT **(CHK # 0034038036)** **$1,013.28**

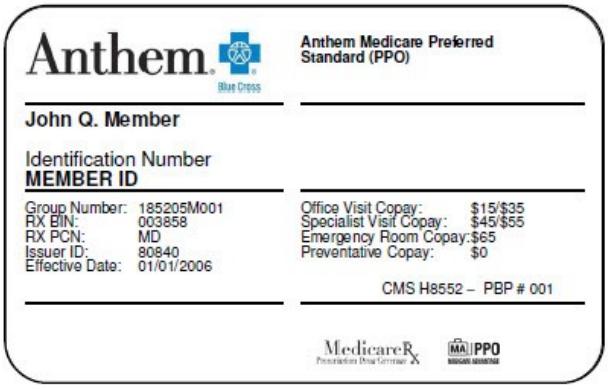
Federal Employee Program ID Cards

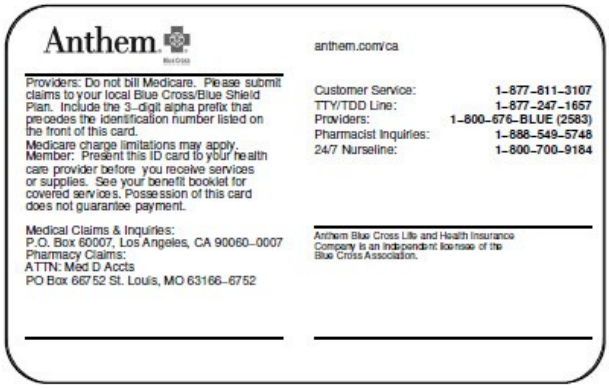
Standard Option Enrollment Codes (104 – 105)

Basic Option Enrollment Codes (111 – 112)

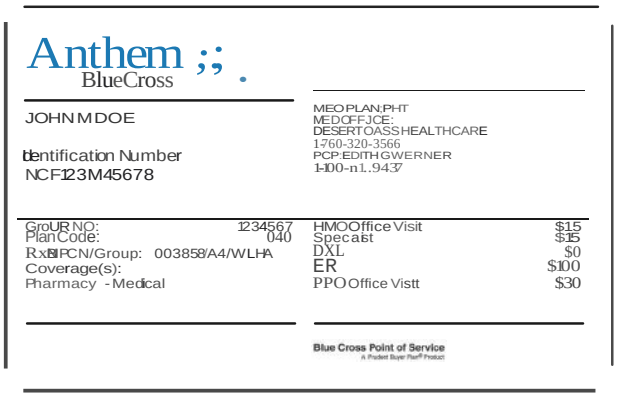


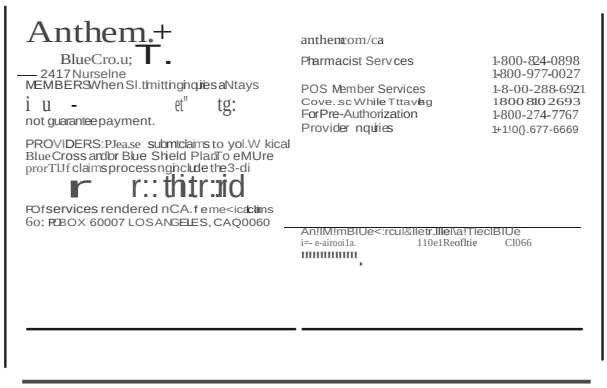
Blue Cross Medicare Preferred PPO ID Card



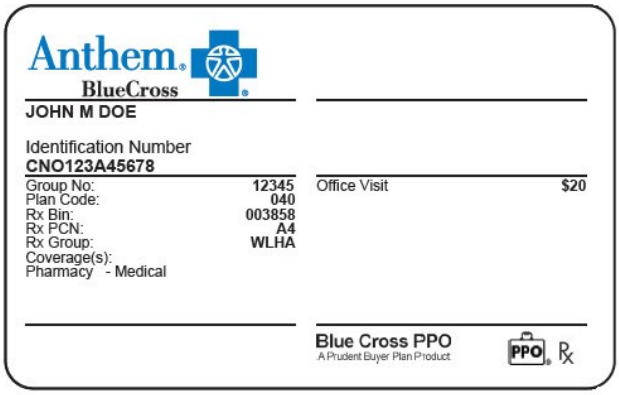


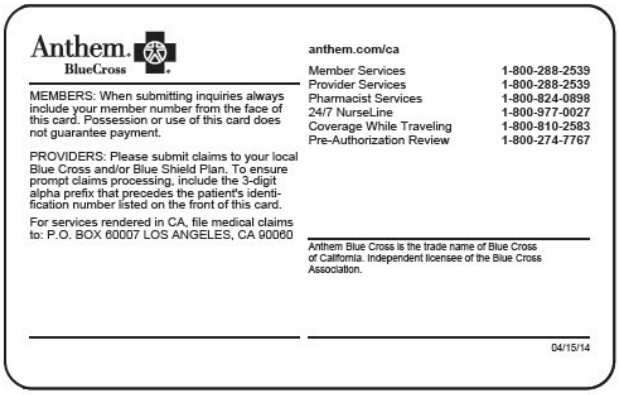
Blue Cross POS ID Card



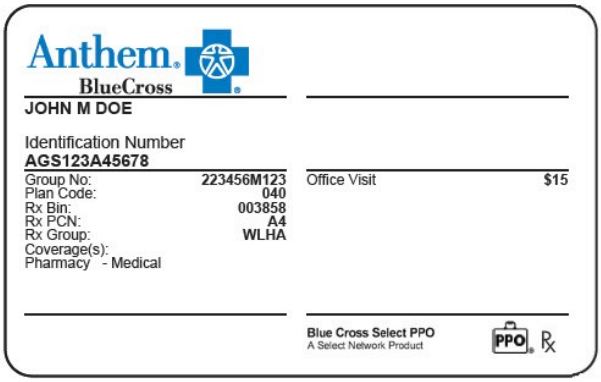


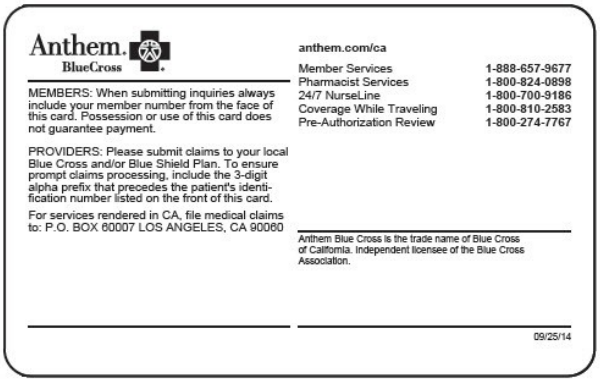
Blue Cross PPO ID Card





Blue Cross Select PPO ID Card





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.

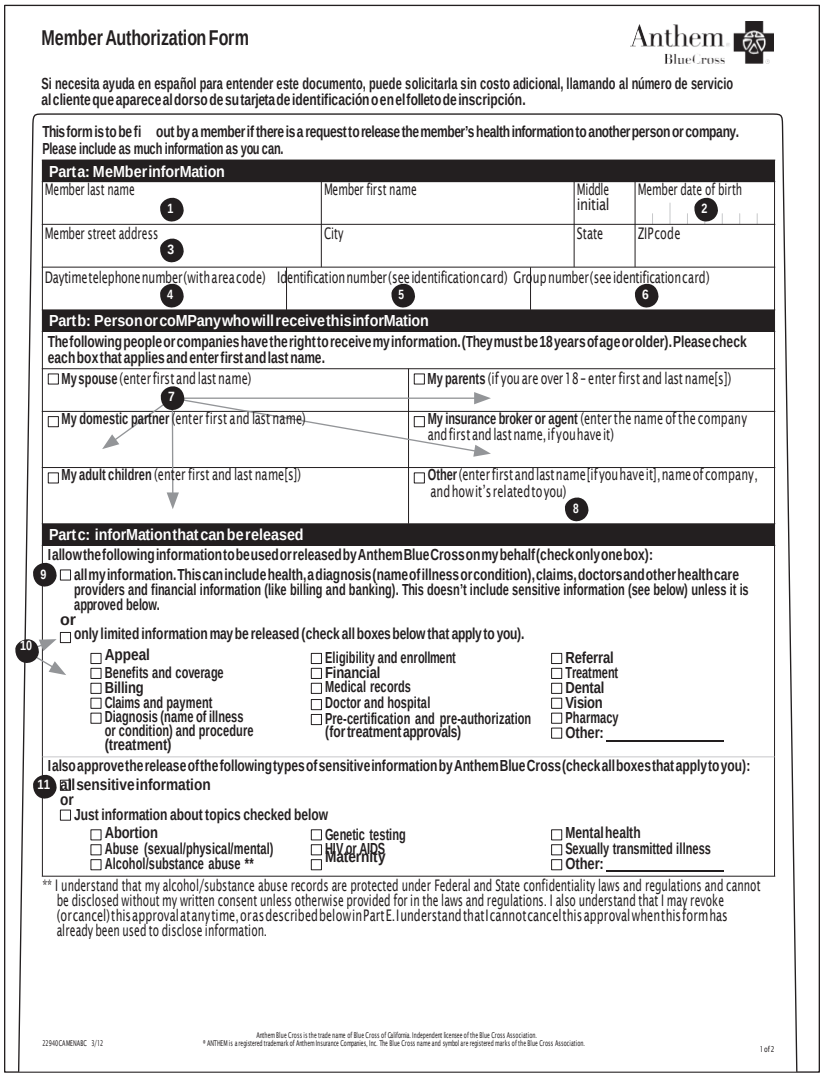
Part a: Member Information

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. 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),



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 fi 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

☐ only limited information may be released (check all boxes below that apply to you). 10

- ☐ 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

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.

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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: dATeyOur 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 _____

PArTF: 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 X				Date

Please return the completed form to:
Anthem Blue Cross

be sure to keep a copy of this form for your records.

FOr reclPIenT 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 fi 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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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 X			Date

Please return the completed form to:

Anthem Blue Cross

be sure to keep a copy of this form for your records.

for reclPIent 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.

Reset Form | Save and Print

For internal use only:	Inquiry tracking number

Using the Search Tool (CD-ROM Version)

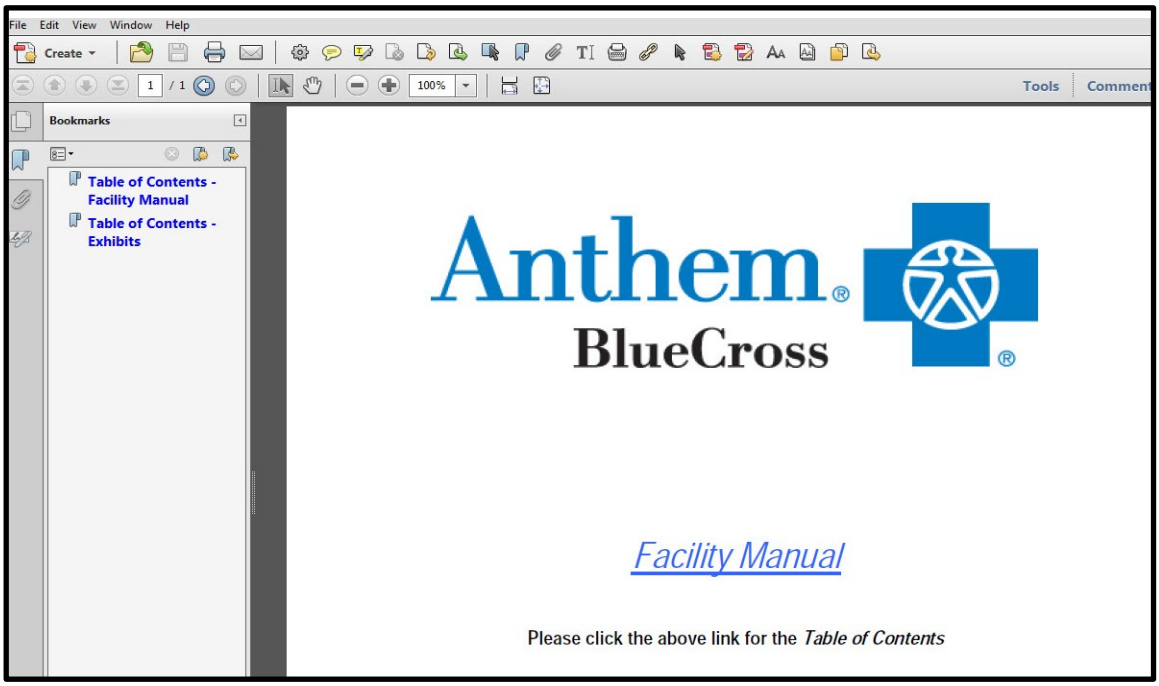
Anthem Blue Cross has created this is a step-by-step guide for searching specific items or key words throughout Anthem Blue Cross manuals. The search tool is a function of Adobe Acrobat, the file format used for our manuals.

Note:

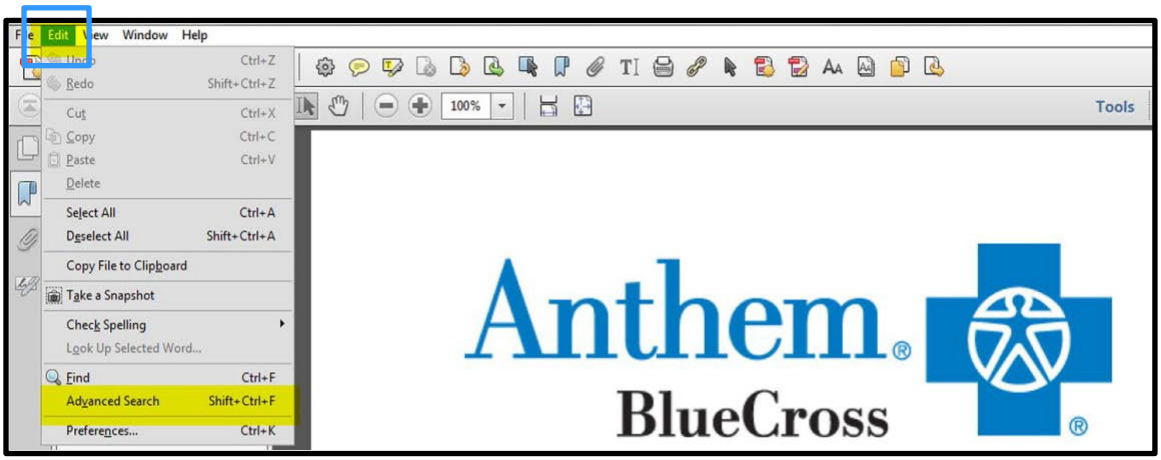
- Search key words when viewing the entire manual on a CD-ROM.
- Search keyword by section only in ProviderAccess®

STEP 1: Insert the CD-ROM of an Anthem Blue Cross Manual 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 on the CD-ROM jacket to open

Example is of the Anthem Blue Cross Facility Manual



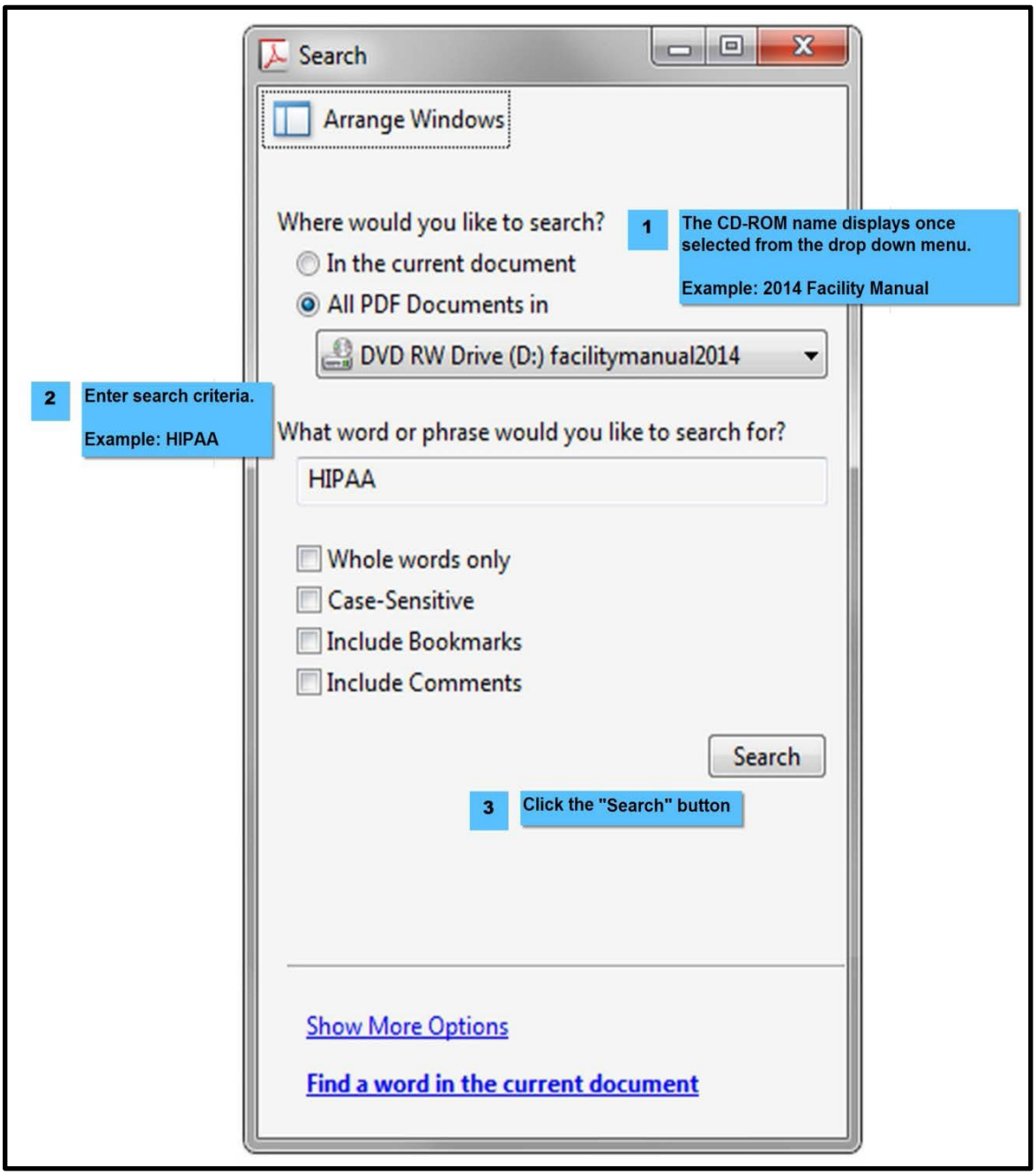
STEP 2: At the top of the page, select the "Edit" tab then the option, "Advanced Search".



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, “2014 Facility Manual” and the letter of the drive (D) displays. The drive letter varies, depending on your computer mapping.

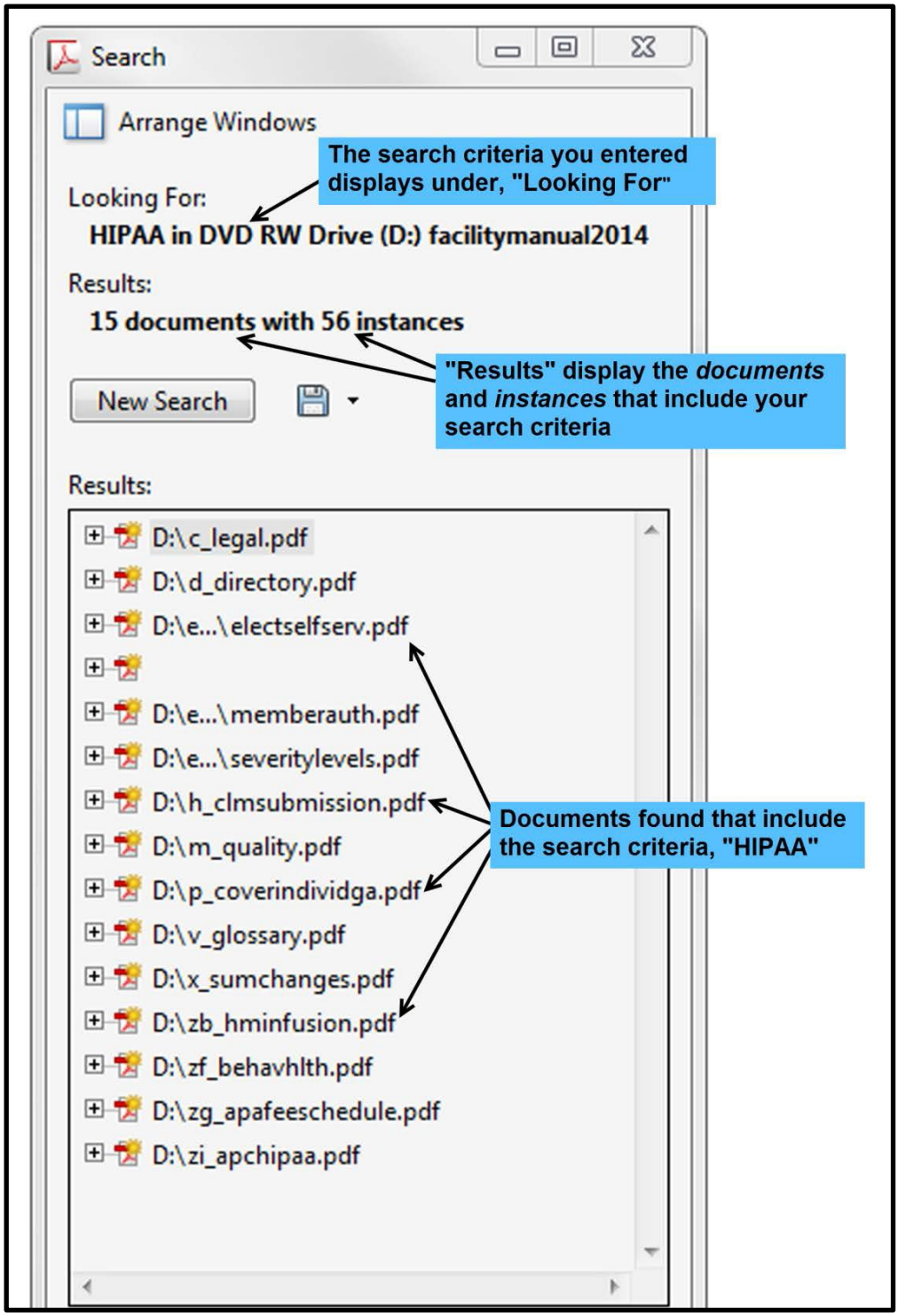
Question 2 **“What word or phrase would you like to search for?”** appears above a free form text box. Enter search criteria, the key word(s) you want to find in the Manual. In this example, “HIPAA” Is entered here.



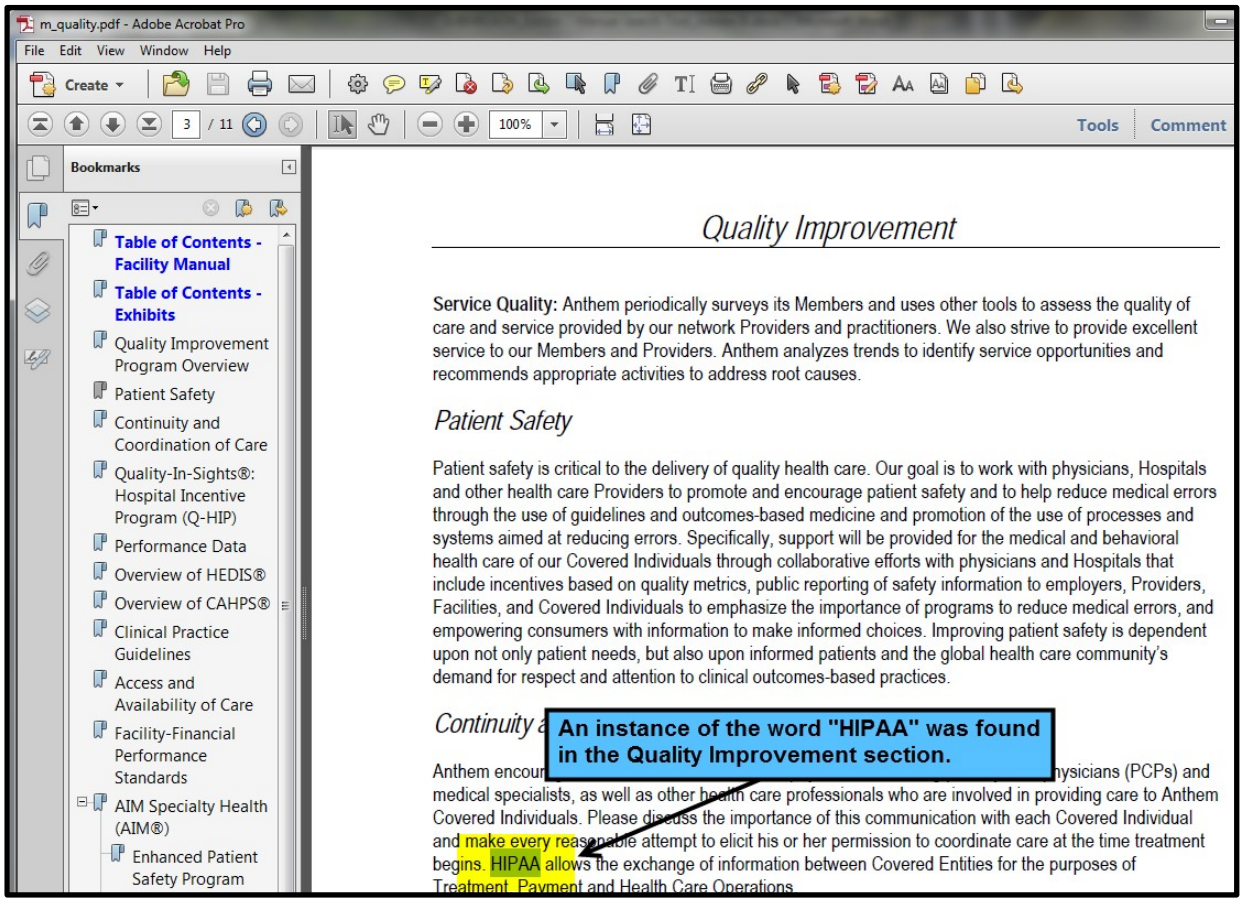
STEP 4: The details of your search display in the window.

A 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).

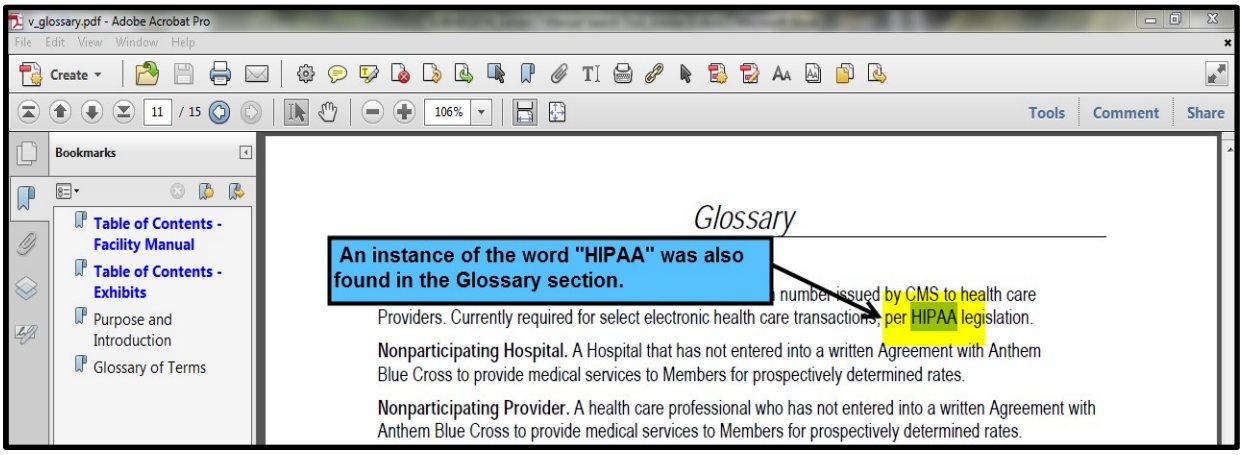
That document or instance is a link which takes you directly to that location in the Manual.



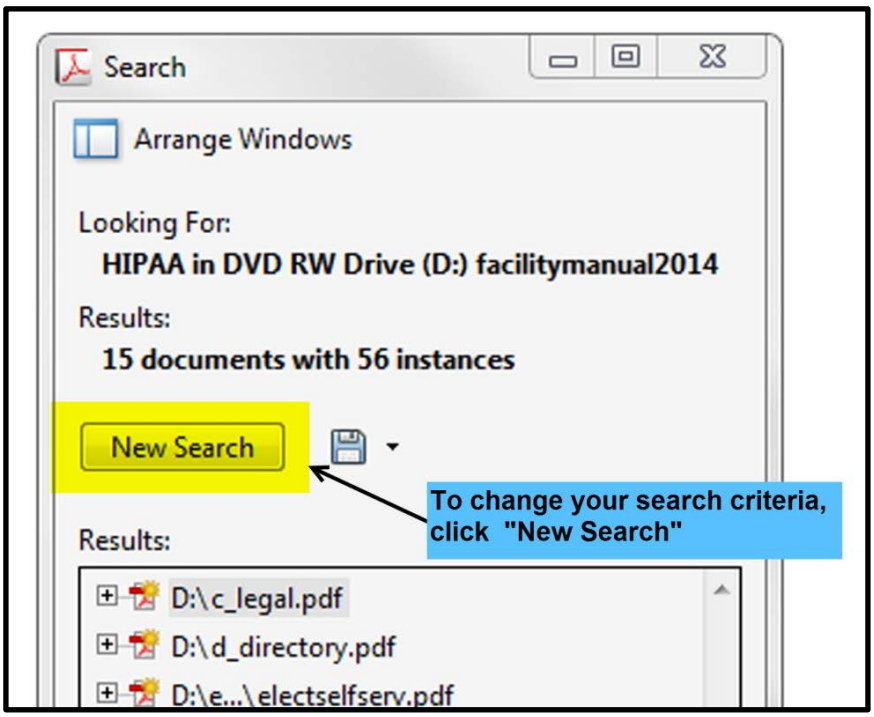
Step 7: Click a document or instance in the "Results" box and you are taken directly to the location of that occurrence.



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.



(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

OUTPATIENT TREATMENT REPORT

INSTRUCTIONS: Please print all information. Fax completed form to (877) 521-4787 (toll-free).

PATIENT Name ID # DOB

PROVIDER *Individual and/or Group*

Name Tax ID # License # Phone #

Address City State ZIP Fax #

ICD-9 DIAGNOSIS *numeric + description*

Axis I

Axis II

Axis III

Axis IV

Axis V

current *highest past year*

MEDICAL CONDITIONS

- ☐ None
- ☐ Asthma/COPD
- ☐ Cancer
- ☐ Cardiovascular Problems
- ☐ Other
- ☐ Chronic Pain
- ☐ Dementia
- ☐ Diabetes
- ☐ Obesity

CURRENT RISK ASSESSMENT

☐ Suicidal ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming self ☐ N/A

☐ Homicidal ☐ Ideation ☐ Plan ☐ Intent ☐ Hx of harming others ☐ N/A

MEDICATIONS

Medication	Psychotropic	Medical	Prescribing MD	PCP	Psychiatrist	Other
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐
	☐	☐		☐	☐	☐

If affective or psychotic disorder is present and no medications are prescribed, please explain:

COORDINATION OF CARE

I have communicated with patient's

☐ PCP ☐ Specialist ☐ Psychiatrist ☐ Therapist

TREATMENT HISTORY

☐ Inpatient: ☐ Within past yr ☐ 1 to 3 yrs ago ☐ More than 3 yrs ago

☐ Outpatient: ☐ Within past yr ☐ 1 to 3 yrs ago ☐ More than 3 yrs ago

SYMPTOMS and FUNCTIONAL IMPAIRMENT *If present, check degree*

On Disability? ☐ Yes ☐ No

	Mild	Moderate	Severe		Mild	Moderate	Severe		Mild	Moderate	Severe
Anxiety	☐	☐	☐	Hopelessness	☐	☐	☐	Obsessions/Compulsions	☐	☐	☐
Decreased Energy	☐	☐	☐	ADLs	☐	☐	☐	Significant Weight Change	☐	☐	☐
Delusions	☐	☐	☐	Family/Relationships	☐	☐	☐	Panic Attacks	☐	☐	☐
Depressed Mood	☐	☐	☐	Inattention	☐	☐	☐	Sleep Disturbance	☐	☐	☐
Hallucinations	☐	☐	☐	Irritability/Mood instability	☐	☐	☐	Physical Health	☐	☐	☐
Hyperactivity	☐	☐	☐	Impulsivity	☐	☐	☐	Work/School	☐	☐	☐
Substance Abuse/Dependence	☐	☐	☐	☐ Active ☐ In Remission							

If Substance Abuse is current or focus of treatment, complete the information below:

Substance of Choice	Amount	Frequency	Date of Last Use
☐ Alcohol			
☐ Marijuana			
☐ Heroin			
☐ Opioids			
☐ Cocaine *list*			
☐ Methamphetamine			
☐ Prescr. Drugs			
☐ Inhalants *list*			

Is patient currently participating in a community-based support group? (Includes AA, NA, etc.) ☐ Yes ☐ No

If Yes, frequency of attendance:

Is there a sponsor? ☐ Yes ☐ No

DESIRED OBSERVABLE OUTCOMES

Patient agrees with treatment goals ☐ Yes ☐ No

PROVIDER'S CONTINUED TREATMENT PLAN

Modality and CPT Code	Frequency	Completion		Anticipated
☐		Individual 90832	☐ ☐	x
☐ per wk mo yr	mo(s)	Individual 90834	☐ ☐	x
☐ per wk mo yr	mo(s)	Individual 90833*	☐ ☐	x
☐ per wk mo yr	mo(s)	Individual 90836*	☐ ☐	x
☐ per wk mo yr	mo(s)	Couple/Family 90847	☐ ☐	x
☐ per wk mo yr	mo(s)	Group 90853	☐ ☐	x
☐ per wk mo yr	mo(s)	Other _____	☐ ☐ ☐	x per

TREATMENT PROGRESS

Level of improvement to date ☐ Minor ☐ Moderate ☐ Major

☐ No progress to date ☐ Maintenance tx of chronic condition

# of sessions provided to date

Start date for new authorization

My signature confirms that I am providing the requested services.

PROVIDER'S SIGNATURE ***DATE***

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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 _____

Behavioral Health/EAP Practice Profile

Behavioral Health Practice Profiles
Provider Database Fax: 818-234-2836
Email: ProviderDatabaseAnthem@anthem.com

EAP Practice Profiles
EAP Fax: 888-438-7957
Email: EAPProviderNetworks@anthem.com

Name of Practitioner _____

Email Address (Required) _____

License Number _____ NPI

Number _____

Practitioner Signature _____

Date _____

To keep our online provider directories up to date, it is important for us to know your areas of expertise. This information helps our clinicians when directing referrals, and members who access care directly. Check all that apply to your primary areas of practice focus.

Open or Closed Practice Status - Is your practice currently accepting new patients? ❑ Yes ❑ No

CLINICAL ORIENTATION
- ❑ Behavioral
- ❑ Biological/Medical
- ❑ Cognitive
- ❑ Cognitive Behavioral
- ❑ Psychodynamic
- ❑ Systems

PATIENTS
- ❑ Children
- ❑ Adolescents (Ages 13-17)
- ❑ Adults (Ages 18+)
- ❑ Geriatrics (Ages 60+)
- ❑ Deaf/Hearing Impaired
- ❑ Disabled Persons

EMPLOYEE ASSISTANCE PROGRAM (EAP)
- ❑ Case Management
- ❑ EAP Counseling
- ❑ Formal/Mandatory Referrals
- ❑ Management Consultations

EAP ACCOUNT SERVICES
- ❑ Critical Incident Stress Debrief
- ❑ EAP Employee Orientations
- ❑ EAP Supervisor Training
- ❑ Executive Coaching
- ❑ Organizational Development
- ❑ Workplace Mediation
- ❑ Workshops/Seminars

AREAS OF EXPERTISE
- ❑ ADD/ADHD
- ❑ Adoption
- ❑ Anti-Psychotic Injectables (MD/DO only)
- ❑ Anxiety and Panic Disorders
- ❑ Autism Spectrum Disorder
- ❑ Bariatric Surgery
- ❑ Behavior Modification
- ❑ Bipolar
- ❑ Brief Solution Focused
- ❑ Chemical Dependency
- ❑ Chemical Dependency Assessment
- ❑ Christian Counseling
- ❑ Compulsive Gambling
- ❑ Cultural/Ethnic Issues
- ❑ Depressive Disorders
- ❑ Dialectical Behavioral Therapy
- ❑ Divorce/Blended Family Issues
- ❑ Domestic Violence
- ❑ Eating Disorders
- ❑ Electroconvulsive Therapy
- ❑ End of Life Issues
- ❑ Family Therapy
- ❑ Fitness-for-Duty Assessments
- ❑ Gay/Lesbian Issues
- ❑ Group Therapy
- ❑ HIV/AIDS Related Issues
- ❑ Infertility
- ❑ Medication Management (MD/DO/PMHNP only)
- ❑ Men Issues
- ❑ Obsessive Compulsive Disorder
- ❑ Pain Management
- ❑ Personality Disorders
- ❑ Postpartum Issues
- ❑ Prenatal Issues
- ❑ Psychological Testing
- ❑ Schizophrenia/Schizoaffective Disorder
- ❑ Sexual Abuse
- ❑ Sexual Disorders
- ❑ Suboxone
- ❑ Transcranial Magnetic Stimulation (TMS)
- ❑ Transgender Issues
- ❑ Victims of Abuse, Assault, Trauma
- ❑ Women Issues

1. Can you conduct therapy in any language(s) other than English? ❑ Yes ❑ No

   If yes, please specify language(s): _____

2. Do you treat Workers' Compensation? (MD/DO/PhD/PsyD only) ❑ Yes ❑ No
   If no, you will not be included in our *Other Payor Medical Provider Network (MPN)* to treat work related injuries. Participating practitioners should contact Anthem Workers' Compensation MPN Services at 866-700-2168 to "opt out".

3. Please select your ethnic origin (Optional: this information will be utilized in online provider directories available to our customers)

   ❑ Asian Indian ❑ Native American (i.e. American Indian, Eskimo, Aleut or Native Hawaiian)
   ❑ African-American ❑ Pacific-Asian ❑Hispanic ❑ White, Non-Hispanic

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Practice Update Form

Behavioral Health Practice Changes
Provider Database Fax: 818-234-2836 ProviderDatabaseAnthem@anthem.com

Medi-Cal Practice Changes
Medi-Cal Fax: 877-608-6752
ssbdatamanagementservices@anthem.com

EAP Practice Changes
EAP Fax: 888-438-7957
EAPProviderNetworks@anthem.com

Instructions:

- ✓ Address information should correspond to **only one Tax Identification Number** (Tax ID) **per form**. A **W-9 is required** when replacing/adding a Tax ID.
- ✓ Complete an additional form if there are other addresses associated with the Tax ID that cannot be listed below.
- ✓ **Complete the entire form.** E-mail or fax the completed form to the appropriate Network Database area listed above.
- ✓ If contracted with more than one network, **submit the completed form to all Network Database areas that apply.**

1. Tax ID *(Provide only one Tax ID)*_____ License_____ Rendering NPI *(Type 1)* _____
2. Name_____ BACB® Cert# *(If applicable)* _____
3. Accepting New Patients? ❑ Yes ❑ No E-mail Address *(Required)* _____
4. Check/EOB/Remit Address *(Provide where to send reimbursement or payment)*

DELETE			ADD		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

5. Mailing/Correspondence Address *(Provide where to send contractual and fee notices, newsletters and correspondence if different from Check/EOB)*

DELETE			ADD		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

6. Office Address 1 *(Provide a physical practice address, where patients are seen)*

DELETE			ADD		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

7. Office Address 2 *(Provide a physical practice address, where patients are seen)*

DELETE			ADD		
Address			Address		
City	State	Zip	City	State	Zip
Phone	Fax		Phone	Fax	

8. Practitioner's Signature *(Required)* _____ Date:_____

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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)

Page_____of _____

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Revised May 2014

Request for Network Provider Pricing

- ***ProviderAccess®*** offers on-line pricing. Log-on → select **CLAIMS** tab.
- **Please type or print legibly.**

Name of Physician or Medical Group & Contact Name	**Telephone Number**
Street Address	**Fax Number**
City, State, and ZIP Code	**NPI / Tax ID Number**

INTERNAL USE - Completed by Anthem Blue Cross: Contract Code_____NRS initials _____

	CPT Code	**Modifier**	**Description**	**Anthem Blue Cross (Anthem) Prudent Buyer Plan Maximum Allowable** (To be completed by Anthem)
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Please email or fax completed form to:

Anthem Blue Cross
Attention: Network Relations
Fax: (818) 234-3148
Email: CAcontractsupport@anthem.com
If you have questions, please call (855) 238-0095.

Note:
This pricing is current rates and assumes each procedure was **performed within a single visit or day.** Anthem's unit values are subject to change. The maximum allowables are subject to the terms of the members' benefit agreement, including co-payments and deductibles. Each claim may be subject to utilization and/or medical review.

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Enterprise 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

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, adequacy of the waiting-room and examining-room space, handicap access and record keeping; for tracking and trending. {CR-5}
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.

1/1/13

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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