Anthem Blue Cross
Cal MediConnect Plan

Santa Clara County

Provider Manual

Effective January 1, 2015
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CHAPTER 1: INTRODUCTION

Welcome to the Anthem Blue Cross Cal MediConnect Plan

Welcome to the Anthem Blue Cross Cal MediConnect plan, network of dedicated physicians and Providers. Anthem Blue Cross has been selected by the California Department of Health Care Services (DHCS) to participate in the three-year demonstration called Cal MediConnect. As part of California’s Coordinated Care Initiative, the goal of this program is to integrate care for those dual-eligible individuals who are enrolled in both the Medicare and Medicaid health plans. By consolidating the responsibility for all the covered services into a single health plan, we expect to see improved quality of care for our members, and improve continuity of care across acute care, long-term care, behavioral health and home-and-community based services using a patient-centered approach.

At Anthem Blue Cross, our goals are to assist you in providing unequaled care to your patients while making the practice of medicine more rewarding in terms of better patient outcomes, better practice economics and diminished practice difficulties. By furnishing the means to accomplish these ends and by helping you and your patients access them, we are confident you will be proud to have joined us.

Service Area

The definition of a service area, as described by the Member Handbook (also called the Evidence of Coverage or EOC), is the geographic area approved by DHCS and the Centers for Medicare and Medicaid Services (CMS) in which a person must live to become or remain a Member of the Anthem Blue Cross Cal MediConnect. Members who are temporarily away from the service area for a period of six months or less are eligible to receive emergency and urgently needed services outside the service area.

Santa Clara County is the service areas for the Anthem Blue Cross Cal MediConnect Plan.

Using This Manual

Designed for Anthem Blue Cross physicians, hospitals, Long Term Services and Supports (LTSS) Providers and ancillary Providers who are participating in the Anthem Blue Cross Cal MediConnect Plan, this manual is a useful reference guide for you and your office staff. We recognize that managing our Members’ health can be a complex undertaking. It requires familiarity with the rules and requirements of a system that encompasses a wide array of health care services and responsibilities. We want to help you navigate our managed health care plan to find the most reliable, responsible, timely and cost-effective ways to deliver quality health care to our Members.

This manual is available on the website at www.anthem.com/CA. Providers may view it online, download it to their desktop or print it out from the site. If you have questions about the manual, please contact our Cal MediConnect Customer Care team at 1-855-817-5786.

There are many advantages to accessing this manual at our website, including the ability to link to any section by clicking on the topic in the Table of Contents. Each section may also contain important phone numbers, as well as cross links to other sections, our website or outside websites containing additional information. Bold type may draw attention to important information.
Provider Self-Service Website

Anthem Blue Cross provides access to a website, www.anthem.com/CA that contains the full complement of online Provider resources. The website features an online Provider Inquiry Tool to reduce unnecessary telephone calls by enabling easy access at your convenience to the following resources:

- Online support services, such as:
  - New user registration and activation, login help, and user name and password reset
  - Forms to update Provider demographics and information such as tax ID or group affiliation changes

- Interactive look-up tools and reference materials, such as:
  - Provider/referral directories
  - Precertification lookup tool
  - Claims status/submission tool
  - Reimbursement policies
  - Provider Manuals are available via the Provider website or through your local Provider Relations representative

Anthem Blue Cross also offers a dedicated Provider Services team called Cal MediConnect Customer Care to assist with precertification and notification, health plan network information, Member eligibility, claims information, and inquiries. The team can also take any recommendations you may have for improving our processes and managed care program.

Legal and Administrative Requirements

Disclaimer

The information provided in this manual is intended to be informative and to assist Providers in navigating the various aspects of participation with the Anthem Blue Cross Cal MediConnect Plan. Unless otherwise specified in the Provider Agreement, the information contained in this manual is not binding upon Anthem Blue Cross and is subject to change. Anthem Blue Cross will make reasonable efforts to notify Providers of changes to the content of this manual.

This manual may be updated at any time and is subject to change. In the event of an inconsistency between information contained in this manual and the Provider Agreement between you or your facility and Anthem Blue Cross, the Agreement shall govern.

In the event of a material change to the Provider Manual, Anthem Blue Cross will make all reasonable efforts to notify you in advance of such changes through provider bulletins, provider newsletters, and other mailings. In such cases, the most recently published information shall supersede all previous information and be considered the current directive.

The manual is not intended to be a complete statement of all Anthem Blue Cross Cal MediConnect Plan policies or procedures. Other policies and procedures not included in this manual may be posted on our website or published in specially-targeted communications.
These communications include, but are not limited to letters, bulletins and newsletters. Throughout this manual, there are instances where information is provided as a sample or example. This information is meant to illustrate only and is not intended to be used or relied upon in any circumstance or instance.

This manual does not contain legal, tax or medical advice. Please consult other advisors for such advice.

**Third Party Websites**

The *Anthem Blue Cross* website and this manual may contain links and references to Internet sites owned and maintained by third party entities. Neither *Anthem Blue Cross* nor its related affiliated companies operate or control in any respect any information, products or services on these third-party sites. Such information, products, services and related materials are provided “as is” without warranties of any kind, either express or implied, to the fullest extent permitted under applicable laws. *Anthem Blue Cross* disclaims all warranties, express or implied, including but not limited to implied warranties of merchantability and fitness. *Anthem Blue Cross* does not warrant or make any representations regarding the use or results of the use of third-party materials in terms of their correctness, accuracy, timeliness, reliability or otherwise.

**Privacy and Security Statements**

*Anthem Blue Cross*’s latest privacy and security statements related to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) can be found on the *Anthem Blue Cross* website. To find these statements, go to [www.anthem.com/CA](http://www.anthem.com/CA)

Please be aware that when you travel from the *Anthem Blue Cross* website to another website, whether through links provided by *Anthem Blue Cross* or otherwise, you will be subject to the privacy policies (or lack thereof) of the other sites. We caution you to determine the privacy policy of such websites before providing any personal information.

**Misrouted Protected Health Information**

Providers and facilities are required to review all Member information received from *Anthem Blue Cross* to ensure no misrouted protected health information (PHI) is included. Misrouted PHI includes information about Members that a Provider or facility is not treating or are not enrolled to your practice. PHI can be misrouted to Providers and facilities by mail, fax, email or electronic remittance advice. Providers and facilities are required to destroy immediately any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or facilities permitted to misuse or re-disclose misrouted PHI. If Providers or facilities cannot destroy or safeguard misrouted PHI, please contact Provider Relations at Cal MediConnect Customer Care **1-855-817-5786**.

**Collection of Personal and Clinical Information**

*Anthem Blue Cross* will collect and release all personal and clinical information related to Members in keeping with California and Federal laws, including HIPAA, court orders or subpoenas. Release of records according to valid court orders or subpoenas are subject to the provisions of that court order or subpoena.
The person or entity that is seeking to obtain medical information must obtain the authorization from the Member and is to use that information only for the purpose it was requested and retains it only for the duration needed.

The individual physician or Provider may not intentionally share, sell or otherwise use any medical information for any purpose not necessary to provide health care services to the Member.

Only necessary information shall be collected and maintained. Reasons for collecting medical information may include but are not limited to:

- To review for medical necessity of care
- To perform quality management, utilization management and credentialing/re-credentialing functions
- To determine the appropriate payment under the benefit for covered services; to analyze aggregate data for benefit rating, quality improvement and oversight activities, etc.
- To comply with statutory and regulatory requirements

**Maintenance of Confidential Information**

Anthem Blue Cross maintains confidential information as follows:

- Clinical information received verbally may be documented in the Anthem Blue Cross database. This database includes a secured system restricting access to only those with authorized entry. Computers are protected by a password known only to the computer user assigned to that computer. Computers with any computer screen displaying Member or Provider information shall not be left on and unattended.

- Electronic, facsimile or written clinical information received is secured, with limited access to employees to facilitate appropriate Member care and reimbursement for such care. No confidential information or documents are left unattended (i.e., open carts, bins or trays at any time). Hard copies of all documents are not visible at any workstation during the employee’s breaks, lunch or time spent away from desks.

- Written clinical information is stamped “Confidential,” with a warning that its release is subject to California and Federal law.

- Confidential information is stored in a secure area with access limited to specified employees, and medical information is disposed of in a manner that maintains confidentiality (i.e., paper shredding and destroying of recycle bin materials).

- Any confidential information used in reporting to other departments or to conduct training activities, which may include unauthorized staff, will be “sanitized” (i.e., all identifying information blacked out), to prevent the disclosure of confidential medical information.

- Any records related to quality of care, unexpected incidence investigations or other peer review matters are privileged communications. As such, these records are maintained as confidential. All such written information is stamped “Confidential” with a warning that its
release is subject to state and federal law. Information is maintained in locked files.

**Member Consent**

Member authorization is not required for treatment, payment and health care operations. Direct treatment relationships, (i.e., the provision and/or coordination of health care by Providers), requires Member consent.

**Member Access to Medical Records**

Members may access their medical records upon proper request. Upon reviewed and approved requests to Anthem Blue Cross’s compliance office, the Member may provide a written amendment to their records if they believe that the records are incomplete or inaccurate.

No written request is required for information/documents to which a Member would normally have access, such as copies of claims, etc. Anthem Blue Cross substantiates the identity of the individual Member (i.e., subscriber number, date of service, etc.) before releasing any information.

A written request signed by a Member or the Member’s authorized representative is required to release medical records. An initial “consent to treat” may be signed at the point of entry into services prior to the provision of those services, but does not allow records to be released for any reasons other than those delineated in that original consent (i.e., payment and specialty referral authorization processes)

Anthem Blue Cross will assist the Member who has difficulty obtaining requested medical records.

**Release of Confidential Information**

**Members Considered Incompetent or Lacking the Legal Capacity to Give Consent to Medical Treatment**

Incompetent Members include:

- A Member/conservatee who has been declared incompetent to consent to treatment by a court
- A Member/conservatee who has not been declared incompetent to consent to treatment, but whom the treating physician determines lacks the capacity to consent
- A Member who is not capable of understanding the nature and effect of the proposed treatment

Anthem Blue Cross will consult with legal counsel, as appropriate. The Durable Power of Attorney or Letters of Conservatorship may need to be reviewed by legal counsel to determine who may consent to the release of Member information.
Release to Providers

Provider requests may be honored if the request pertains to that Provider’s services. All other requests require the Member’s or Member representative’s signed release for the information.

Electronic, facsimile or written clinical information sent is secured with limited access to those employees who are facilitating appropriate patient care and reimbursement for such care.

Release of Outpatient Psychotherapy Records

Anyone requesting Member outpatient psychotherapy records must submit a written request, except when the patient has signed a written letter or form waiving notification to the Member and treating Provider. The request must be sent to the Member within 30 days of the receipt of the records except when the Member has signed a written letter or form waiving notification.

The written request must be signed by the requestor and must identify:

- What information is requested
- The purpose of the request and
- The length of time the information will be kept

A person or entity may extend the timeframe, provided that the person or entity notifies the practitioner of the extension. Any notification of the extension will include:

- The specific reason for the extension
- The intended use or uses of the information during the extended time and
- The expected date of the destruction of the information

The request will include a statement that:

- The information will not be used for any purpose other than its intended use and
- That the requestor will destroy the information when it is no longer needed (including how the documents will be destroyed)

The request must specifically include the following:

- Statement that the information will not be used for any purpose other than its intended use
- Statement that the person or entity requesting the information will destroy the information when it is no longer needed
- Specifics on how the information will be destroyed, or specify that the person or entity will return the information and all copies of it before or immediately after the length of time indicated in the request and
- Specific criteria and process for confidentially faxing and copying outpatient psychotherapy records
Release of Records Pursuant to a Subpoena

Member information will only be released in compliance with a *subpoena duces tecum* received by *Anthem Blue Cross* as follows:

- The subpoena is to be accepted, dated and timed by the above person or designee.
- The subpoena should give *Anthem Blue Cross* at least 20 days from the date the subpoena is issued to allow a reasonable time for the Member to object to the subpoena and/or preparation and travel to the designated stated location.
- All subpoenas must be accompanied by either a written authorization for the release of medical records or a “proof of service” demonstrating the Member has been “served” with a copy of the subpoena.
- Alcohol or substance abuse records are protected by both Federal and State law (42 CFR § 2.1 et seq.) and may not be released unless there is also a court order for release which complies with the specific requirements.
- Only the requested information will be submitted (HIV and AIDS information is excluded). HIV and AIDS or AIDS related information require a specific subpoena.
- Should a notice contesting the subpoena be received prior to the required date, records will not be released without a court order requiring so. If no notice is received, records will be released at the end of the 20-day period.

The record will be sent through the U.S. Postal Service by registered receipt or certified mail.

Archived Files/Medical Records

All medical records are retained by *Anthem Blue Cross* and / or the delegated / contracted medical groups, as well as individual practitioner offices, according to the following criteria:

- Adult patient charts – 10 years
- X-Rays – 10 years
# CHAPTER 2: CONTACTS

## Contacts

### Overview

<table>
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<th>Quick Reference Information</th>
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<tr>
<td><strong>Cal MediConnect Customer Care</strong></td>
<td>Contact the Cal MediConnect Customer Care at <strong>1-855-817-5786</strong> for Member Eligibility, Nurse HelpLine and Pharmacy Services</td>
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<tr>
<td><strong>Member Services</strong></td>
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<tr>
<td>o Telephone: <strong>1-855-817-5785</strong></td>
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<tr>
<td>o TTY: 1-800-855-2880</td>
<td></td>
</tr>
<tr>
<td><strong>AT&amp;T Relay Service</strong></td>
<td>For English call 1-800-855-2880; for Spanish call 1-800-855-2884</td>
</tr>
<tr>
<td><strong>Medical Notification/Precertification</strong></td>
<td></td>
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<tr>
<td>• May be telephoned, submitted online or faxed to <strong>Anthem Blue Cross</strong>:</td>
<td></td>
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<tr>
<td>o Telephone: <strong>1-855-817-5786</strong></td>
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<tr>
<td>• Web: <a href="http://www.anthem.com/CA">www.anthem.com/CA</a></td>
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<tr>
<td>• Data required for complete notification/precertification:</td>
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<tr>
<td>- Member ID number</td>
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<tr>
<td>- Legible name of referring Provider</td>
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<tr>
<td>- Legible name of individual referred to Provider</td>
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<tr>
<td>- Number of visits/services requested</td>
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<tr>
<td>- Dates of service</td>
<td></td>
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<tr>
<td>- Diagnosis</td>
<td></td>
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<tr>
<td>- Current Procedural Terminology (CPT) code or other code for services to be provided</td>
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<tr>
<td>• Clinical staff is available during normal business hours from 8 a.m. to 6 p.m. local time</td>
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<tr>
<td>• Clinical information supporting need for services is required for precertification; the Precertification Request Form is also available online.</td>
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<tr>
<td><strong>Claims Submission: Paper</strong></td>
<td>Submit paper claims to:</td>
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<td></td>
<td><strong>Anthem Blue Cross</strong></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 60007</td>
</tr>
<tr>
<td></td>
<td>Los Angeles, CA 90060-0007</td>
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<td>Claims Submission: Electronic</td>
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<td><strong>Electronic</strong></td>
<td>Electronic filing methods are preferred for accuracy, convenience and speed. <strong>Electronic Data Interchange</strong> (EDI) allows providers to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions. For more information on EDI, please contact the <strong>Anthem EDI Solutions Helpdesk</strong> at 1-800-470-9630, Monday to Friday, 8 a.m. to 4:30 p.m., Eastern time or email EDI Solutions at <a href="mailto:ent.edi.support@anthem.com">ent.edi.support@anthem.com</a></td>
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<td>The following Sender/Payer IDs should be used when filing electronic claims/transactions through Anthem Blue Cross Payer ID assignment for claims submitted through a clearinghouse or a software vendor should be verified with the vendor to ensure the correct value is assigned to the claim transaction. Many clearing agencies use proprietary Payer IDs; therefore, we do not assign or maintain payer ID codes for other entities, clearinghouses or vendors.</td>
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<tr>
<td><strong>Professional</strong></td>
<td><strong>Institutional</strong></td>
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<td>47198</td>
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<tr>
<td>National Provider Identifier</td>
<td>National Provider Identifier (NPI) — The Health Insurance Portability and Accountability Act (HIPAA) of 1996 requires the adoption of a standard unique Provider identifier for health care Providers. All Anthem Blue Cross Cal MediConnect Plan participating Providers must have an NPI number. Definition for those not required. Atypical Provider: An individual or business that is not a health care provider and does not meet the definition of a health care provider according to the NPI rules. Therefore, these types of providers do not require an NPI number. The NPI is a 10-digit intelligence-free numeric identifier. Intelligence-free means the numbers do not carry information about health care Providers, such as the state in which they practice or their specialty. Providers can apply for an NPI by completing an application: • Online at <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a> (Estimated time to complete the NPI application is 20 minutes) • By downloading a paper copy at <a href="https://nppes.cms.hhs.gov">https://nppes.cms.hhs.gov</a> • By calling 1-800-465-3203 and requesting an application Please send your NPI to: Provider Data Management Anthem Blue Cross P. O. Box 27401 Richmond, VA 23279-7401 Email: <a href="mailto:NPImail@anthem.com">NPImail@anthem.com</a></td>
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</tbody>
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<th>Quick Reference Information</th>
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| **Administrative Complaints/Payment Disputes** | Administrative complaints and payment disputes are determined by the liable party, not by the initiator. The time frame to review your request will commence once your request is routed to the appropriate department. Please refer to the denial letter or Explanation of Payment (EOP) issued to determine the correct request process. Administrative complaints/payment disputes must be filed within 120 calendar days of the initial *Anthem Blue Cross* decision. Send administrative complaints/payment disputes to:  
  Payment Disputes  
  *Anthem Blue Cross*  
  P.O. Box 61599  
  Virginia Beach, VA 23466-1599 |
| **Behavioral Health Services** | Beacon Health Strategies  
  Provider Services:  
  Santa Clara County- **1-855-371-2283**  
  Monday through Friday from 8 a.m. to 8 p.m. local time |
### Quick Reference Information

| **Member Appeals** | Appeals initiated by a member or by a Provider on the Member’s behalf are determined by the liable party, not by the initiator. Please refer to the denial letter or EOP issued to determine the correct appeals process to follow. All Member appeals should be sent to:  
**Complaints, Appeals and Grievances Department**  
**Anthem Blue Cross**  
P.O. Box 61116  
Virginia Beach, VA 23466-1599  
Phone: 1-855-817-5787  
Fax: 1-855-856-1724  

A Member or a Provider acting on behalf of a Member and with the Member’s written consent may appeal the decision to deny, terminate, suspend or reduce services.  

In the event that failure to provide the service is life- or limb-threatening or that waiting the standard appeal time frame would be harmful to the Member, an expedited or fast appeal can be initiated by contacting us in one of the following ways:  
**Complaints, Appeals and Grievances Department**  
**Anthem Blue Cross**  
P.O. Box 61116  
Virginia Beach, VA 23466-1599  
Phone: 1-855-817-5787  
Fax: 1-855-856-1724  

Please indicate if you are requesting an expedited appeal. |
| **Nonemergent Transportation** | LogistiCare  
Reservations: **1-855-608-5172** Monday through Friday from 6 a.m. to 6 p.m. local time  
| **Provider Service Representatives** | For more information, contact Provider Services at Cal MediConnect Customer Care at **1-855-817-5786**. |
| **Translation / Interpreter Services** | For assistance with translation services for your patients, please contact Provider Services at Cal MediConnect Customer Care at **1-855-817-5786**. |
Quick Reference Information

<table>
<thead>
<tr>
<th>Vision Services</th>
<th>VSP – 1-800-615-1883</th>
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<tr>
<td></td>
<td>Monday through Friday from 5 a.m. to 8 p.m. local time</td>
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<td>Saturday 7 a.m. through 8 p.m. local time</td>
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<td>Sunday 7 a.m. through 7 p.m. local time.</td>
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<td>(TTY – 800-428-4833)</td>
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<tr>
<td></td>
<td>Website: <a href="http://www.vsp.com">www.vsp.com</a></td>
</tr>
<tr>
<td>Pharmacy Prior Authorization</td>
<td>Contact Cal MediConnect Customer Care at 1-855-817-5786 or via fax at 1-800-359-5781</td>
</tr>
</tbody>
</table>

Contacts

Ongoing Provider Communications and Feedback

To ensure Providers are up-to-date with information required to work effectively with [Anthem Blue Cross](https://www.anthem.com) and our Members, we provide frequent communications to Providers in the form of broadcast faxes, Provider Manual updates, newsletters and information posted to the website.
CHAPTER 3: PARTICIPATING PROVIDER INFORMATION

Participating Provider Information
The Anthem Blue Cross Cal MediConnect Plan Provider Network

Anthem Blue Cross Cal MediConnect Plan Members obtain covered services by choosing a Primary Care Provider (PCP) who is part of the Anthem Blue Cross Cal MediConnect Plan Network to assist and coordinate their care. Members are encouraged to coordinate with their PCP before seeking care from a specialist, except in the case of specified services (such as women’s routine and preventive care and behavioral health care).

Note: Some services provided by a specialist may require precertification or a referral.

When referring a Member to a specialist, it’s critical to select a participating Provider within our network to maximize the Member’s benefit. If you need help finding a participating Provider, please call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786.

Participating Provider Information
The Primary Care Provider Role

Members are asked to select a PCP when enrolling in the Anthem Blue Cross Cal MediConnect Plan and may change their selected PCP at any time. Anthem Blue Cross contracts with certain physicians that Members may choose as their PCPs and may be individual practitioners associated with a contracted medical group or an independent practice association. The PCP is responsible for referring or obtaining precertification for covered services for Members. Participating PCPs are generally physicians of internal medicine, family practitioners, general practitioners, pediatricians, obstetricians/gynecologists or geriatricians. Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) may be included as PCPs.

The PCP is a network physician who has responsibility for the complete care of his or her Members, whether providing it himself or herself or by referral to the appropriate Provider of care within the network.

Each Member has a Care Manager and an Interdisciplinary Care Team (ICT) assigned to assist with developing care plans, collaborating with other team Members and providing recommendations for the management of the Member’s care.

When coordinating Member care, the PCP should refer the Member to a participating Provider within the Anthem Blue Cross Cal MediConnect Plan Network. To assist the specialty care Provider, the PCP should provide the specialist with the following clinical information:

- Member name
- Referring PCP
- Reason for the consultation
- History of the present illness
- Diagnostic procedures and results
- Pertinent past medical history
• Current medications and treatments
• Problem list and diagnosis
• Specific request of the specialist

Any referral to a nonparticipating Provider will require precertification from Anthem Blue Cross, or the services may not be covered. Contact Provider Services at Cal MediConnect Customer Care at 1-855-817-5786 for questions or more information.

Participating Provider Information

Health Risk Assessments

Anthem Blue Cross believes that quality primary care and active care coordination are essential components to providing high-quality and cost-effective health care to our Members. This philosophy supports the relationship between our contracted PCPs and other health care professionals who coordinate the medical needs of our Members. The goal is to ensure each Member receives appropriate care and all of his or her Providers are in communication with one another so that the Member achieves healthier outcomes.

A Health Risk Assessment (HRA) is a comprehensive questionnaire used by the Anthem Blue Cross Cal MediConnect plan to obtain basic health information from Members.

A Physician Health Risk Assessment (PHRA) is a questionnaire used to obtain basic health information from Members that supplements the HRA performed by the Anthem Blue Cross Cal MediConnect Plan. PCPs complete the PHRA during a visit with an Anthem Blue Cross Cal MediConnect Plan Member and record the results on the form. The PHRA supplements the comprehensive HRA performed by the MMP.

To successfully complete the PHRA, the following fields must be legibly documented for processing and claims reimbursement:

• Patient name and Anthem Blue Cross Cal MediConnect Plan ID number
• Physician name and NPI
• Date of assessment
• Physician signature included on each page

The PHRA will then be forwarded to the Care Management team to assist in the development and implementation of the members Plan of Care (POC).

To obtain a copy of the PHRA form, please access our website at www.anthem.com/CA
Participating Provider Information

The Specialist’s Role

A specialist is any licensed Provider (as defined by Medicare) providing specialty medical services to Members. A PCP may refer a Member to a specialist when medically necessary. Specialists must obtain authorization from **Anthem Blue Cross** before performing certain procedures or when referring Members to non-contracted Providers. You can review precertification requirements online at www.anthem.com/CA or call Provider Services at Cal MediConnect Customer Care at **1-855-817-5786**.

After performing the initial consultation with a Member, a specialist should:

- Communicate the Member’s condition and recommendations for treatment or follow-up care with the PCP
- Send the PCP the consultation report, including medical findings, test results, assessment, treatment plan and any other pertinent information
- If the specialist needs to refer a Member to another Provider, the referral should be to another **Anthem Blue Cross Cal MediConnect Plan** Provider. Any referral to a nonparticipating Provider will require precertification from **Anthem Blue Cross**

Participating Provider Information

Specialist Acting as a PCP

In some cases, a specialist, physician assistant, nurse practitioner or certified nurse midwife under physician supervision may be a PCP. This must be authorized by the health plan’s Case Management department. If you have any questions, contact Cal MediConnect Customer Care. To download a copy of the Specialist as a PCP Form, visit www.anthem.com/CA.

Participating Provider Information

Participating Provider Responsibilities

- Manage the medical and health care needs of Members, including monitoring and following up on care provided by other Providers, providing coordination necessary for services provided by specialists and ancillary Providers (both in and out-of-network) and maintaining a medical record meeting **Anthem Blue Cross** standards
- Provide coverage 24 hours a day, 7 days a week; regular hours of operation should be clearly defined and communicated to Members
- Provide all services ethically, legally and in a culturally competent manner and meet the unique needs of Members with special health care needs
- Participate in systems established by **Anthem Blue Cross** to facilitate the sharing of records, subject to applicable confidentiality and HIPAA requirements
• Make provisions to communicate in the language or fashion primarily used by his or her assigned Members
• Provide hearing interpreter services upon request to Members who are deaf or hard of hearing
• Participate in and cooperate with Anthem Blue Cross in any reasonable internal and external quality assurance, utilization review, continuing education and other similar programs established by Anthem Blue Cross
• Comply with Medicare, DHCS and California laws, regulations and CMS instructions, agree to audits and inspections by CMS and/or its designees, cooperate, assist and provide information as requested, and maintain records for a minimum of 10 years
• Participate in and cooperate with the Anthem Blue Cross Cal MediConnect Plan appeal and grievance procedures
• **Agree to not balance bill** Members for monies that are not their responsibility
• Continue care in progress during and after termination of a Provider’s contract for up to 90 days, or such longer period of time (up to six months) as required by state laws and regulations, until a continuity of service plan is in place to transition the Member to another network Provider
• Comply with all applicable federal and state laws regarding the confidentiality of patient records
• Develop and have an exposure control plan in compliance with Occupational Safety and Health Administration (OSHA) standards regarding blood-borne pathogens
• Establish an appropriate mechanism to fulfill obligations under the Americans with Disabilities Act of 1990 (ADA)
• Support, cooperate and comply with Anthem Blue Cross Cal MediConnect Plan Quality Improvement program initiatives and any related policies and procedures to provide quality care in a cost-effective and reasonable manner
• Inform Anthem Blue Cross if a Member objects to the provisions of any counseling, treatments or referral services for religious reasons
• Treat all Members with respect and dignity, provide appropriate privacy, and treat Member disclosures and records confidentially, giving Members the opportunity to approve or refuse their release
• Provide Members complete information concerning their diagnosis, evaluation, treatment and prognosis and give them the opportunity to participate in decisions involving their health care, except when contraindicated for medical reasons
• Advise Members about their health status, medical care or treatment options, regardless of whether benefits for such care are provided under the program and advise them on treatments that may be self-administered
• When clinically indicated, contact Members as quickly as possible for follow-up regarding significant problems and/or abnormal laboratory or radiological findings
• Have a policy and procedure to ensure proper identification, handling, transport, treatment and disposal of hazardous and contaminated materials and wastes to minimize sources and transmission of infection

• Agree to maintain communication with the appropriate agencies such as local police, social services agencies and poison control centers to provide high-quality patient care

• Agree any notation in a Member’s clinical record indicating diagnostic or therapeutic intervention as part of the clinical research will be clearly contrasted with entries regarding the provision of non-research-related care

• If a Member self-refers or a Provider is referring to another Provider, that Provider is responsible for checking the Anthem Blue Cross Cal MediConnect Plan Provider directory to ensure the specialist is in the network. Referrals to Anthem Blue Cross contracted specialists do not require precertification. Some procedures performed by specialist physicians may require precertification. Please refer to the Summary of Benefits document or Member Handbook for procedures that require precertification or call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. If you cannot locate a Provider in the Anthem Blue Cross Cal MediConnect Plan Network, you should contact Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. You must obtain authorization from Anthem Blue Cross before referring Members to non-contracted Providers. Additionally, certain services/procedures require precertification from Anthem Blue Cross

• Provider agrees to use any laboratory designated by the IPA Network for Anthem Blue Cross Cal MediConnect Members. Anthem Blue Cross will reimburse for a limited list of lab services. This is not applicable to standalone Skilled Nursing Facilities.

Note: Anthem Blue Cross does not cover the use of any experimental procedures or experimental medications, except under certain circumstances.

Participating Provider Information
Provider Responsibilities in the Management of Transitions in Care

A transition in care for a Member is defined as a point at which the Member’s care is transferred from one Provider to another or from a facility to another level of care. Examples of transitions in care include a referral from a PCP to a specialist, an admission to a hospital or a discharge from a hospital to home care or a skilled nursing facility.

When a Member experiences a transition in care, it is the responsibility of the transferring Provider to do the following:

• Notify the Member in advance of a planned transition

• Provide documentation of the care plan to the receiving institution or Provider within one business day of the transition

• Communicate with the Member about the transition process

• Communicate with the Member about his or her health status and plan of care
Chapter 3: PARTICIPATING PROVIDER INFORMATION

- Notify the Member’s usual practitioner of the transition within three business days after notification of the transition
- Provide a treatment plan/discharge instructions to the Member prior to discharge
- Notify the Member’s Care Manager at Anthem Blue Cross

The Provider is an integral part of effectively managing transitions. Communication is the key both with the Member and other treating Providers. To prevent duplicate testing and provide critical information about the Member, the following processes should be followed:

- The referring physician or Provider should provide the relevant patient history to the receiving Provider
- Any pertinent diagnostic results should be forwarded to the receiving Provider
- The receiving Provider should communicate a treatment plan back to the referring Provider
- Any diagnostic test results ordered by the receiving Provider should be communicated to the referring Provider

Participating Provider Information

Enrollment and Eligibility Verification

All health care Providers are responsible for verifying enrollment and eligibility before services are rendered, except in the case of an emergency. In general, eligibility should be verified at the time of service and at least once monthly for ongoing services. In an emergency, eligibility should be determined as soon as possible after the Member’s condition is stabilized. When a patient presents as a Member, Providers must verify eligibility, enrollment and coverage by performing the following steps:

Request the Member’s Anthem Blue Cross Cal MediConnect Plan card; if there are questions regarding the information, call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786 to verify eligibility, deductibles, coinsurance amounts, copayments and other benefit information or use the online Provider inquiry tool www.anthem.com/CA.

- Copy both sides of the Member’s Anthem Blue Cross Cal MediConnect Plan card and place the copies in the Member’s medical record
- Copy the member’s driver’s license (if applicable) to ensure the member’s information matches their Anthem Blue Cross Cal MediConnect Plan card and place the copies in the member’s medical record
- If you are a PCP, check your Anthem Blue Cross Cal MediConnect Plan Member Panel Listing to ensure you are the Member’s doctor
- If the patient does not have an identification card, use the online Provider inquiry tool at www.anthem.com/CA or call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786.
Participating Provider Information

Identification Card for the Anthem Blue Cross Cal MediConnect Plan

The Member will have a single ID card for the Anthem Blue Cross Cal MediConnect Plan

Participating Provider Information

Member Missed Appointments

Members may sometimes cancel or not appear for necessary appointments and fail to reschedule the appointment. This can be detrimental to their health. **Anthem Blue Cross** requires Providers to attempt to contact Members who have not shown up for or canceled an appointment without rescheduling. The contact must be by telephone and should be designed to educate the Member about the importance of keeping appointments and to encourage the Member to reschedule the appointment.

Members who frequently cancel or fail to show up for appointments without rescheduling may need additional education in appropriate methods of accessing care. In these cases, please call Provider Services at Cal MediConnect Customer Care at **1-855-817-5786** to address the situation. **Anthem Blue Cross** staff will contact the Member and provide more extensive education and/or case management as appropriate. **Anthem Blue Cross**’s goal is for Members to recognize the importance of maintaining preventive health visits and to adhere to a plan of care recommended by their PCP.

Participating Provider Information

Non-compliant Anthem Blue Cross Cal MediConnect Plan Members

**Anthem Blue Cross** recognizes Providers may need help in managing non-adherent Members. If you have an issue with a Member regarding behavior, treatment cooperation, completion of treatment and/or making or appearing for appointments, call Provider Services at Cal MediConnect Customer Care at **1-855-817-5786**. A Member or Provider Services representative will contact the Member by telephone, or a Member advocate will visit the Member to provide
education and counseling to address the situation and will report the outcome of any counseling efforts to you.

**Participating Provider Information**

**Second Medical or Surgical Opinion**

At the Member’s request, *Anthem Blue Cross* will provide a second opinion from a qualified health care professional within the *Anthem Blue Cross Cal MediConnect* network.

If there is no Provider in the *Anthem Blue Cross Cal MediConnect* network who can render a second opinion, *Anthem Blue Cross* will arrange for the Member to obtain one outside the network, at no cost.

**Participating Provider Information**

**Access and Availability**

Participating *Anthem Blue Cross Cal MediConnect* Providers must:

- Offer hours of operation that are no less than the hours of operations offered to their other patients (e.g., commercial or public fee for service insured)
- Provide coverage for Members 24 hours a day, 7 days a week
- Ensure another on-call *Anthem Blue Cross Cal MediConnect* Provider is available to administer care when the PCP is not available
- Not substitute hospital emergency rooms or urgent care centers for covering Providers
- See Members within 30 minutes of a scheduled appointment or inform them of the reason for delay (e.g., emergency cases) and offer an alternative appointment
- Provide an after-hours telephone service to ensure a response to emergency phone calls within 30 minutes and a response to urgent phone calls within one hour; individuals who believe they have an emergency medical condition should be directed to immediately seek emergency services from the nearest emergency facility
Participating Provider Information
Access and Availability Standards Table

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<tr>
<th>Type of Appointment (Medical) See Behavioral Health Chapter 6 for specific Behavioral Health Access Standards</th>
<th>Availability Standard</th>
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<tbody>
<tr>
<td>Patient Visit with New PCP</td>
<td>Within 30 calendar days</td>
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<tr>
<td>Routine Follow-up or Preventive Care</td>
<td>As soon as possible but within 30 calendar days</td>
</tr>
<tr>
<td>Routine/Symptomatic</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Non-Urgent Care</td>
<td>Within 7 days</td>
</tr>
<tr>
<td>Urgently Needed Services</td>
<td>Within 24 hours</td>
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<tr>
<td>Emergency</td>
<td>Immediately</td>
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Anthem Blue Cross monitors adherence to appointment availability standards through office visits, long-term care visits, and tracking of complaints and grievances related to access and/or discrimination. Deviations from the policy are reviewed by the Medical Director for educational and/or counseling opportunities and tracked for Provider re-credentialing.

Anthem Blue Cross will ensure newly enrolled Members will continue to have access to medically necessary items, services, prescription drugs, and medical, behavioral health and LTSS Providers for the transition period. Members will be allowed to maintain their current Providers for 180 days from the date of enrollment. Members will also be allowed to maintain their preauthorized services for the duration of the prior authorization or 180 days from enrollment, whichever is sooner.

Anthem Blue Cross will also advise, in writing, both Members and Providers when Members have received care that would not otherwise be covered at an in-network level. Anthem Blue Cross will contact non-contracted Providers to inform them on the procedure for becoming an in-network Provider.
Chapter 3: PARTICIPATING PROVIDER INFORMATION

Individuals residing in nursing facilities at the time of program implementation may remain in the facility as long as they continue to meet the California Department of Health Care Services (DHCS) criteria for nursing home care, unless they or their families prefer to move to a different nursing facility or return to the community.

During the transition period referenced above, a change from the existing Provider can only occur in the following circumstances:

- The Member requests a change
- The Provider chooses to discontinue providing services to a Member as currently allowed by Medicare or Medicaid
- Anthem Blue Cross, CMS or DHCS identifies Provider performance issues that affect a Member’s health and welfare or
- The Provider is excluded under State or Federal exclusion requirements

Participating Provider Information

Covering Physicians

During a Provider’s absence or unavailability, the Provider must arrange for coverage for his or her Members. The Provider will either: (i) make arrangements with one or more Anthem Blue Cross Cal MediConnect network Providers to provide care for his or her Members or (ii) make arrangements with another similarly licensed and qualified Provider who has appropriate medical staff privileges at the same network hospital or medical group, as applicable, to provide care to the Members in question. In addition, the covering Provider will agree to the terms and conditions of the network Provider Agreement, including any applicable limitations on compensation, billing and participation. Providers will be solely responsible for a non-network Provider’s adherence to such provisions. Providers will be solely responsible for any fees or monies due and owed to any non-network Provider providing substitute coverage to a Member on the Provider’s behalf.

Participating Provider Information

Reporting Changes in Address and / or Practice Status

Any changes in a Provider’s address and/or practice status can be submitted by sending email to ssbdatamanagementservices@wellpoint.com.
Participating Provider Information

Plan-specific Termination Criteria

The occurrence of any of the following is grounds for termination of the Anthem Blue Cross Cal MediConnect Plan Provider’s participation:

- Loss of reputation among peers due to unethical clinical practice or attitude
- The practice of fraud, waste and/or abuse
- Adverse publicity involving the Provider due to acts of omission or commission
- Substance abuse
- Loss of professional office
- Inadequate record keeping
- Unsafe environment in the Provider’s office relative to inadequate access or other related issues that might cause a Member injury
- An office that is improperly kept or unclean or does not present a proper appearance
- Failure to meet OSHA guidelines
- Failure to meet ADA guidelines
- Failure to meet Clinical Laboratory Improvement Amendments (CLIA) guidelines
- Customer satisfaction ratings that drop below pre-established standards as determined by the Medical Advisory Committee (MAC) (this would include complaints relative to appearance, behavior, medical care, etc.)
- Repetitive complaints about office staff demeanor, presentation and appearance
- Inclusion on the Debarred Providers Listing of the Office of the Inspector General of the Department of Health and Human Services (see Sanctioned Providers section below)
- Unfavorable inpatient- or outpatient-related indicators:
  - Severity-adjusted morbidity and mortality rates above established norms
  - Severity-adjusted length-of-stay above established norms
  - Unfavorable outpatient utilization results
  - Consistent inappropriate referrals to specialists
  - Improper maintenance of high-risk patients, such as those Members with diabetes and hypertension
  - Underutilization relative to minimum standards of care established per medical management guidelines and/or accepted clinical practice in the community
  - Unfavorable malpractice-related issues
  - Frequent litigious activity above and beyond what would be expected for a Provider in that particular specialty

Anthem Blue Cross Cal MediConnect Providers have 30 calendar days to appeal a termination. The Anthem Blue Cross process is designed to comply with all state and federal regulations regarding the termination appeal process.
Participating Provider Information
Incentives and Payment Arrangements

Financial arrangements concerning payment to Providers for services to Members are set forth in each Provider’s agreement with Anthem Blue Cross and Blue Shield or Anthem Blue Cross. Anthem Blue Cross may also use financial incentives to reward Providers for achieving certain quality indicator levels.

Anthem Blue Cross does not use or employ financial incentives that would directly or indirectly induce Providers to limit or reduce medically necessary services furnished to individual enrollees. In cases where Anthem Blue Cross approves Provider subcontracting arrangements, those subcontractors cannot employ any financial incentives inconsistent with this policy or CMS regulations.

Participating Provider Information
Laws Regarding Federal Funds

Payments Providers receive for furnishing services to Members are derived in whole or part from federal funds. Therefore, Providers and any approved subcontractors must comply with certain laws applicable to individuals and entities receiving federal funds, including but not limited to Title VI of the Civil Rights Act of 1964 as implemented by 45 CFR Part 84; the Age Discrimination Act of 1975 as implemented by 45 CFR Part 91; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

Participating Provider Information
Prohibition Against Discrimination

Neither Anthem Blue Cross nor its contracted Providers may deny, limit or condition the coverage or furnishing of services to Members on the basis of any factor related to health status, including but not limited to the following:

- Medical condition, including mental as well as physical illness
- Claims experience
- Receipt of health care
- Medical history
- Genetic information
- Evidence of insurability, including conditions arising out of acts of domestic violence
- Disability
Participating Provider Information
Provider Panel – Closing a Panel

When closing a Provider panel to new Anthem Blue Cross Cal MediConnect Plan Members or other new patients, Providers must:

- Give Anthem Blue Cross prior written notice the Provider panel is closing to new Members as of a specific closing date
- Keep the Provider panel open to Members who were patients of that practice before the panel closed or before they were enrolled with Anthem Blue Cross Cal MediConnect Plan.
- Give Anthem Blue Cross prior written notice when reopening the Provider panel, including a specific reopening date

Participating Provider Information
Provider Panel – Transferring and Terminating Members

Anthem Blue Cross will determine reasonable cause for transferring a Member based on written request and documentation submitted by the Provider. Providers may not transfer a Member to another Provider due to the costs associated with the Member’s covered services.

A Provider may request termination of a Member due to fraud, disruption of medical services or the Member’s repeated failure to make the required reimbursements for services. In such cases, the Provider should contact Cal MediConnect Customer Care at 1-855-817-5786.

Participating Provider Information
Reporting Obligations

Cooperation in Meeting CMS Requirements

Anthem Blue Cross is required to provide information to CMS necessary to administer and evaluate the Cal MediConnect program and to establish and facilitate a process for current and prospective Members to exercise their choice in obtaining services.

Anthem Blue Cross provides the following information:

- Plan quality and performance indicators such as disenrollment rates (for beneficiaries enrolled in the plan the previous two years)
- Information on Member satisfaction
- Information on health outcomes

Providers must cooperate with Anthem Blue Cross in its data reporting obligations by providing Anthem Blue Cross with any information required to meet these obligations in a timely fashion.

Certification of Diagnostic Data

Anthem Blue Cross is required to submit information to CMS necessary to characterize the context and purposes of each encounter between a Member and Provider, supplier, physician
Participating Provider Information

Cultural Competency

Cultural competency is the integration of congruent behaviors, attitudes, structures, policies and procedures that come together in a system or agency or among professionals. Cultural competency assists Providers and Members to:

- Acknowledge the importance of culture and language
- Assess cross-cultural relations
- Embrace cultural strengths with people and communities
- Strive to expand cultural knowledge
- Understand cultural and linguistic differences

Cultural Competence

Understanding those values, beliefs and needs associated with the Member’s age, gender identity, sexual orientation, and/or racial, ethnic, or religious background. Cultural Competence also includes a set of competencies which are required to ensure appropriate, culturally sensitive health care to persons with congenital or acquired disabilities. A competency based on the premise of respect for Member and cultural differences and an implementation of a trust-promoting method of inquiry and assistance.

The quality of the Patient-Provider interaction has a profound impact on the ability of a patient to communicate symptoms to his or her Provider and to adhere to recommended treatment. Some reasons a Provider needs to be culturally competent include but are not limited to:

- The perception that illness and disease and their causes vary by culture
- The diversity of belief systems related to health, healing and wellness are very diverse
- The fact that culture influences help-seeking behaviors and attitudes toward health care Providers
- The fact that individual preferences affect traditional and nontraditional approaches to health care
- The fact that patients must overcome their personal biases within health care systems
- The fact that health care Providers from culturally and linguistically diverse groups are under-represented in the current service delivery system
Cultural barriers between the Provider and Member can impact the Patient-Provider relationship in many ways, including but not limited to:

- The Member’s level of comfort with the practitioner and the Member’s fear of what might be found upon examination
- The differences in understanding on the part of diverse consumers in the United States health care system
- A fear of rejection of personal health beliefs
- The Member’s expectation of the health care Provider and of the treatment

To be culturally competent, **Anthem Blue Cross** expects Providers serving Members within their geographic locations to demonstrate the following:

**Cultural Awareness**

- The ability to recognize the cultural factors (norms, values, communication patterns and world views) that shape personal and professional behavior
- The ability to modify one’s own behavioral style to respond to the needs of others, while at the same time maintaining one’s objectivity and identity

**Cultural Knowledge**

- Culture plays a crucial role in the formation of health or illness beliefs
- Culture is generally behind a person’s rejection or acceptance of medical advice and treatment
- Different cultures have different attitudes about seeking help
- Feelings about disclosure are culturally unique
- There are differences in the acceptability and effectiveness of treatment modalities in various cultural and ethnic groups
- Verbal and nonverbal language, speech patterns and communication styles vary by culture and ethnic groups
- Resources such as formally trained interpreters should be offered to and used by Members with various cultural and ethnic differences
Cultural Skills

- The ability to understand the basic similarities and differences between and among the cultures of the persons served
- The ability to recognize the values and strengths of different cultures
- The ability to interpret diverse cultural and nonverbal behavior
- The ability to develop perceptions and understanding of other’s needs, values and preferred means of having those needs met
- The ability to identify and integrate the critical cultural elements of a situation to make culturally consistent inferences and to demonstrate consistency in actions
- The ability to recognize the importance of time and the use of group processes to develop and enhance cross-cultural knowledge and understanding
- The ability to withhold judgment, action or speech in the absence of information about a person’s culture
- The ability to listen with respect
- The ability to formulate culturally competent treatment plans
- The ability to use culturally appropriate community resources
- The ability to know when and how to use interpreters and to understand the limitations of using interpreters
- The ability to treat each person uniquely
- The ability to recognize racial and ethnic differences and know when to respond to culturally based cues
- The ability to seek out information
- The ability to use agency resources
- The capacity to respond flexibly to a range of possible solutions
- The acceptance of ethnic differences among people and the understanding of how these differences affect the treatment process
- The willingness to work with clients of various ethnic minority groups

Participating Provider Information

Marketing

Providers may not develop or use any materials that market the Anthem Blue Cross Cal MediConnect Plan without Anthem Blue Cross’s prior written approval. Under program rules, an organization may not distribute any marketing materials or make such materials or forms available to individuals eligible to elect a Cal MediConnect plan unless the materials meet the CMS marketing guidelines and are first submitted to CMS for review and approval. Additionally, Providers can have plan marketing materials in their office as long as marketing materials for all plans the Providers participate in are represented. Providers are allowed to have posters or notifications that show they participate in the Anthem Blue Cross Cal MediConnect Plan as long as the Provider displays posters or notifications from all plans in which they participate.
Participating Provider Information
Americans with Disabilities Act (ADA) Requirements

The Anthem Blue Cross policies and procedures are designed to promote compliance with the ADA. Providers are required to take actions to remove an existing barrier and/or to accommodate the needs of Members who are qualified individuals with a disability. This action plan includes the following:

- Access to an examination room that accommodates a wheelchair
- Access to a lavatory that accommodates a wheelchair
- Elevator or accessible ramp into facilities
- Handicap parking clearly marked unless there is street-side parking
- Street-level access
- Appropriate signage

For more information, please access the ADA website at http://www.ada.gov/.
CHAPTER 4: HEALTH CARE BENEFITS

Health Care Benefits

Member Eligibility

Eligibility to participate in the Cal MediConnect Program must meet the following criteria:

- Age 21 and older at the time of enrollment
- Entitled to benefits under Medicare Part A and enrolled under Medicare Parts B and D, and receiving full Medicaid benefits.
- Must reside in a Demonstration area

Individuals who meet at least one of the exclusion criteria listed below shall be excluded from the Demonstration as appropriate.

- Individuals under age 21
- Individuals who are required to “spend down” income in order to meet Medicaid eligibility requirements, not include members in Long Term Care / Skilled Nursing Facilities
- Individuals for whom DHCS only pays a limited amount each month toward their cost of care (e.g., deductibles), including non-full benefit Medicaid beneficiaries such as:
  - Qualified Medicare Beneficiaries (QMBs)
  - Special Low Income Medicare Beneficiaries (SLMBs)
  - Qualified Disabled Working Individuals (QDWIs) or
  - Qualifying Individuals (QIs)

These individuals may receive Medicaid coverage for the following: Medicare monthly premiums for Part A, Part B or both (carved-out payment); coinsurance, copayment and deductible for Medicare-allowed services; Medicaid-covered services, including those that are not covered by Medicare.

- Individuals who are residents of State Hospitals, ICF/MR facilities, Residential Treatment Facilities or long-stay hospitals. Note that dual eligible individuals residing in NFs will be enrolled in the Demonstration. For more information on eligibility, please see www.calduals.org
- Individuals enrolled in a hospice program. Individuals receiving hospice services at the time of enrollment will be excluded from the Demonstration. If an individual enters a hospice program while enrolled in the Demonstration, he/she will be dis-enrolled from the Demonstration. However, plans shall refer these individuals to the
- Individuals receiving the end stage renal disease (ESRD) Medicare benefit at the time of enrollment into the Demonstration. However, an individual who develops ESRD while enrolled in the Demonstration will remain in the Demonstration, unless he/she opts out. If he/she opts out, the individual cannot opt back into the Demonstration.
• Individuals with other comprehensive group or individual health insurance coverage other than full benefit Medicare; insurance provided to military dependents; and any other insurance purchased through the Health Insurance Premium Payment Program (HIPP).

• Individuals who have a Medicaid eligibility period that is less than three months.

• Individuals who have a Medicaid eligibility period that is only retroactive.

• Individuals enrolled in the Money Follows the Person (MFP) Program.

• Individuals residing outside of the Demonstration areas.

• Individuals enrolled in a Program of All-Inclusive Care for the Elderly (PACE). However, PACE participants may enroll in the Demonstration if they choose to disenroll from their PACE Provider.

• Individuals participating in the CMS Independence at Home (IAH) demonstration. However, IAH participants may enroll in the Demonstration if they choose to dis-enroll from IAH.

Health Care Benefits

Role of the Enrollment Broker

To support enrollment decisions, the California Department of Health Care Services (DHCS) will ensure that enrollees are educated on Cal MediConnect benefits and Anthem Blue Cross Cal MediConnect networks, the process for opting out of the Demonstration and for changing Managed Care Organizations (MCOs). DHCS will focus on developing clear and accessible information (ensuring availability in alternative formats and languages) on available MCOs and consumer protections. To help facilitate enrollment choices, DHCS will contract with a neutral enrollment broker to:

• Help educate enrollees
• Assist with enrollment and MCO selection
• Operate a toll-free enrollee helpline

Health Care Benefits

Summary of the Benefits Tables

Notations regarding some benefit categories are listed below. Please note availability and limitations. Please refer to the appropriate Summary of Benefits listed below for detailed information.

Precertification requirements are described in later sections and in detail on the Provider website. All services from non-contracted Providers with the exceptions of urgent and emergent care and out-of-area dialysis require precertification.

The medical benefits are further explained in the following sections.
## Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abdominal aortic aneurysm screening</td>
<td>• Coverage – includes one ultrasound screening for people at risk. Members must obtain a referral during “Welcome to Medicare” preventive visit.</td>
</tr>
</tbody>
</table>
| Alcohol misuse screening and counseling      | • Coverage includes one alcohol-misuse screening (SBIRT) for adults who misuse alcohol but are not alcohol dependent. This includes pregnant women.  
• Members who screen positive for alcohol misuse can get up to four brief, face-to-face counseling sessions each year with a qualified primary care provider or practitioner in a primary care setting. |
| Ambulance services                           | Covered ambulance services include fixed-wing, rotary-wing, and ground ambulance services. The ambulance will take member to the nearest place to provide care. 
Member condition must be serious enough that other ways of getting to a place of care could risk member’s life or health. Ambulance services for other cases must be approved by Anthem Blue Cross. 
In cases that are not emergencies, Anthem may pay for an ambulance. The member’s condition must be serious enough that other ways of getting to a place of care could risk member’s life or health. |
<p>| Annual wellness visit                        | Members can get an annual checkup. This is to make or update a prevention plan based on your current risk factors. Anthem will pay for this once every 12 months. |</p>
<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Bone mass measurement</strong></td>
</tr>
<tr>
<td>Coverage includes certain procedures for members who</td>
</tr>
<tr>
<td>qualify (usually, someone at risk of losing bone mass</td>
</tr>
<tr>
<td>or at risk of osteoporosis). These procedures identify</td>
</tr>
<tr>
<td>bone mass, find bone loss, or find out bone quality.</td>
</tr>
<tr>
<td>Anthem will pay for the services once every 24 months</td>
</tr>
<tr>
<td>or more often if they are medically necessary. Anthem</td>
</tr>
<tr>
<td>will also pay for a provider to look at and comment</td>
</tr>
<tr>
<td>on the results.</td>
</tr>
<tr>
<td><strong>Breast cancer screening</strong></td>
</tr>
<tr>
<td>(mammograms)</td>
</tr>
<tr>
<td>Coverage includes the following services:</td>
</tr>
<tr>
<td> One baseline mammogram between the ages of 35 and 39</td>
</tr>
<tr>
<td> One screening mammogram every 12 months for women</td>
</tr>
<tr>
<td>age 40 and older</td>
</tr>
<tr>
<td>Clinical breast exams once every 24 months</td>
</tr>
<tr>
<td><strong>Cardiac (heart) rehabilitation services</strong></td>
</tr>
<tr>
<td>Coverage includes cardiac rehabilitation services</td>
</tr>
<tr>
<td>such as exercise, education, and counseling. Members</td>
</tr>
<tr>
<td>must meet certain conditions with a doctor’s referral</td>
</tr>
<tr>
<td>Coverage also includes intensive cardiac rehabilitation programs.</td>
</tr>
<tr>
<td><strong>Cardiovascular (heart) disease risk reduction</strong></td>
</tr>
<tr>
<td>visit (therapy for heart disease)**</td>
</tr>
<tr>
<td>Coverage includes one visit a year with primary care</td>
</tr>
<tr>
<td>provider to help lower your risk for heart disease.</td>
</tr>
<tr>
<td>During this visit, providers may:</td>
</tr>
<tr>
<td> Discuss aspirin use,</td>
</tr>
<tr>
<td> Check blood pressure, and/or</td>
</tr>
<tr>
<td> Provider information to make sure members are</td>
</tr>
<tr>
<td>eating well.</td>
</tr>
</tbody>
</table>
## Covered Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Cardiovascular (heart) disease testing</strong></td>
<td>Coverage includes blood tests to check for cardiovascular disease once every five years (60 months). These blood tests also check for defects due to high risk of heart disease.</td>
</tr>
</tbody>
</table>
| **Cervical and vaginal cancer screening** | Coverage includes:  
  - For all women: Pap tests and pelvic exams once every 24 months  
  - For women who are at high risk of cervical cancer: one Pap test every 12 months  
  - For women who have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months |
| **Chiropractic services** | Coverage includes the following services:  
  - Adjustments of the spine to correct alignment.  
  Chiropractic services under Medicaid are limited to one (1) service per day, up to a maximum of two (2) services in any one calendar month. |
### Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Colorectal cancer screening**  | Coverage for members 50 and older includes the following services:  
  - Flexible sigmoidoscopy (or screening barium enema) every 48 months  
  - Fecal occult blood test, every 12 months  
  For members at high risk of colorectal cancer, Anthem will pay for one screening colonoscopy (or screening barium enema) every 24 months  
  For people not at high risk of colorectal cancer, Anthem will pay for one screening colonoscopy every ten years (but not within 48 months of a screening sigmoidoscopy). |
| **Community Based Adult Services (CBAS)** | CBAS is an outpatient, facility based service program where people attend according to a schedule. It delivers skilled nursing care, social services, therapies (including occupational, physical, and speech), personal care, family/caregiver training and support, nutrition services, transportation, and other services. Anthem will cover CBAS if you meet the eligibility criteria.  
*Note: If a CBAS facility is not available, Anthem can provide these services separately.* |
### Covered Services

| Counseling to stop smoking or tobacco use | If a member uses tobacco but does not have signs or symptoms of tobacco-related disease:
| --- | --- |
| | ▪ Anthem will cover two counseling quit attempts in a 12-month period as a preventive service. This service is free for the member. Each counseling attempt includes up to four face-to-face visits.
| | If a member uses tobacco and has been diagnosed with a tobacco-related disease or is taking medicine that may be affected by tobacco:
| | ▪ Anthem will cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits.
| | If a member is pregnant, they may receive unlimited tobacco cessation counseling with prior authorization.
| Dental services | Benefits including dentures will be provided by the state’s Denti-Cal program starting May 1, 2014. These services are not provided through our Anthem. For more information, members may call Denti-Cal at 1-800-322-6384. TTY users should call 1-800-735-2922.
| Depression screening | Coverage includes one depression screening each year. The screening must be done in a primary care setting that can give follow-up treatment and referrals. |
## Covered Services

<table>
<thead>
<tr>
<th>Diabetes screening</th>
<th>Coverage includes screening (including fasting glucose tests) if the member has any of the following risk factors:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- High blood pressure (hypertension)</td>
</tr>
<tr>
<td></td>
<td>- History of abnormal cholesterol and triglyceride levels (dyslipidemia)</td>
</tr>
<tr>
<td></td>
<td>- Obesity</td>
</tr>
<tr>
<td></td>
<td>- History of high blood sugar (glucose)</td>
</tr>
<tr>
<td></td>
<td>Tests may be covered in some other cases, such as if the member is overweight and has a family history of diabetes.</td>
</tr>
<tr>
<td></td>
<td>Depending on the test results, members may qualify for up to two diabetes screenings every 12 months.</td>
</tr>
</tbody>
</table>
## Covered Services

### Diabetic self-management training, services, and supplies

Coverage includes the following services for all members who have diabetes (whether they use insulin or not):

- **Supplies to monitor blood glucose**, including the following:
  - A blood glucose monitor
  - Blood glucose test strips
  - Lancet devices and lancets
  - Glucose-control solutions for checking the accuracy of test strips and monitors

- **Members with diabetes who have severe diabetic foot disease**, Anthem covers the following:
  - One pair of therapeutic custom-molded shoes (including inserts) and two extra pairs of inserts each calendar year, or
  - One pair of depth shoes and three pairs of inserts each year (not including the non-customized removable inserts provided with such shoes)

Coverage also includes fitting the therapeutic custom-molded shoes or depth shoes.

- **Training to help members manage their diabetes**, in some cases.

### Durable medical equipment and related supplies

The following items are covered:

- Wheelchairs
- Crutches
- Hospital beds
- Nebulizers

Other items *may* be covered.
### Covered Services

<table>
<thead>
<tr>
<th>Emergency care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency care means services that are:</td>
</tr>
<tr>
<td>- Given by a provider trained to give emergency services, <em>and</em></td>
</tr>
<tr>
<td>- Needed to treat a medical emergency.</td>
</tr>
</tbody>
</table>

*A medical emergency* is a medical condition with severe pain or serious injury. The condition is so serious that, if it doesn’t get immediate medical attention, anyone with an average knowledge of health and medicine could expect it to result in:

- Placing the person’s health in serious risk; *or*
- Serious harm to bodily functions; *or*
- Serious dysfunction of any bodily organ or part; *or*
- In the case of a pregnant woman, an active labor, meaning labor at a time when either of the following would occur:
  - There is not enough time to safely transfer the member to another hospital before delivery.
  - The transfer may pose a threat to the health or safety of the member or unborn child.

*Emergency care is not covered outside the U.S. and its territories except under limited circumstances. Contact us for details.*
## Covered Services

### Family planning services

Members may choose any provider for certain family planning services. Coverage includes the following services:

- Family planning exam and medical treatment
- Family planning lab and diagnostic tests
- Family planning methods (birth control pills, patch, ring, IUD, injections, implants)
- Family planning supplies with prescription (condom, sponge, foam, film, diaphragm, cap)
- Counseling and diagnosis of infertility, and related services
- Counseling and testing for sexually transmitted infections (STIs), AIDS, and other HIV-related conditions
- Treatment for sexually transmitted infections (STIs)
- Voluntary sterilization (Members must be age 21 or older, and must sign a federal sterilization consent form. At least 30 days, but not more than 180 days, must pass between the date that you sign the form and the date of surgery.)
- Genetic counseling

Coverage also includes some other family planning services, however the members must see a provider in our provider network for the following services:

- Treatment for medical conditions of infertility (This service does not include artificial ways to become pregnant.)
- Treatment for AIDS and other HIV-related conditions
- Genetic testing
## Covered Services

| Health and wellness education programs | Coverage includes programs that focus on certain health conditions. These include:  
|---------------------------------------|----------------------------------------------------------------------------------|
|                                       | ▪ Health Education classes;  
|                                       | ▪ Nutrition Education classes;  
|                                       | ▪ Smoking and Tobacco Use Cessation; and  
|                                       | ▪ Nursing Hotline |
| Hearing services                       | Coverage includes hearing and balance tests. They are covered as outpatient care when a member gets them from a physician, audiologist, or other qualified provider.  
|                                       | Members under 21 years old, pregnant, or reside in a nursing facility, coverage includes hearing aids up to $1510 per year, including:  
|                                       | ▪ Molds, supplies, and inserts  
|                                       | ▪ Repairs that cost more than $25 per repair  
|                                       | ▪ An initial set of batteries  
|                                       | ▪ Six visits for training, adjustments, and fitting with the same vendor after the member gets the hearing aid  
|                                       | ▪ Trial period rental of hearing aids  
<p>| Supplemental hearing benefits are limited to as follows: | One routine hearing exam every calendar year |</p>
<table>
<thead>
<tr>
<th>Covered Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV screening</td>
<td>Coverage includes one HIV screening exam every 12 months for members who:</td>
</tr>
<tr>
<td></td>
<td>- Ask for an HIV screening test, or</td>
</tr>
<tr>
<td></td>
<td>- Are at increased risk for HIV infection.</td>
</tr>
<tr>
<td></td>
<td>For women who are pregnant, coverage includes up to three HIV screening tests during a pregnancy.</td>
</tr>
<tr>
<td>Home health agency care</td>
<td>Coverage includes the following services, and maybe other services not listed here:</td>
</tr>
<tr>
<td></td>
<td>- Physical therapy, occupational therapy, and speech therapy</td>
</tr>
<tr>
<td></td>
<td>- Medical and social services</td>
</tr>
<tr>
<td></td>
<td>- Medical equipment and supplies</td>
</tr>
<tr>
<td>Covered Services</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td></td>
</tr>
<tr>
<td>Hospice care</td>
<td></td>
</tr>
</tbody>
</table>

Coverage is available from any hospice program certified by Medicare. The hospice provider can be a network provider or an out-of-network provider.

Coverage includes the following:
- Drugs to treat symptoms and pain
- Short-term respite care
- Home care

*For hospice services and services covered by Medicare Part A or B that relate to a member’s terminal illness:*

- The hospice provider will bill Medicare for services. Medicare will pay for hospice services and any Medicare Part A or B services.

*For services covered by Medicare Part A or B that are not related to terminal illness (except for emergency care or urgently needed care):*

- The provider will bill Medicare for services. Medicare will pay for the services covered by Medicare Part A or B.

*For services covered by Anthem Blue Cross Cal MediConnect Plan but not covered by Medicare Part A or B:*

- Anthem Blue Cross Cal MediConnect Plan will cover plan-covered services not covered under Medicare Part A or B. The plan will cover the services whether or not they are related to terminal illness.

Any Medi-Cal eligible member certified by a physician as having a life expectancy of six months or less may elect to receive hospice care in lieu of normal Medi-Cal coverage for services related to the terminal condition. Covered hospice services include routine home care, continuous home care, respite care, general inpatient care, and specialty physician services.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospice care</strong></td>
<td><strong>Coverage includes two 90-day periods, followed by an unlimited number of 60-day periods. Any covered services provided after the member’s election of the hospice benefit becomes the financial responsibility of the hospice.</strong></td>
</tr>
<tr>
<td><strong>(continued)</strong></td>
<td></td>
</tr>
<tr>
<td><strong>For drugs that may be covered by Anthem Blue Cross Cal MediConnect Plan’s Medicare Part D benefit:</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> If a member needs non-hospice care, member should contact their case manager to arrange the services. Non-hospice care is care that is not related to your terminal illness.</td>
<td></td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td><strong>Coverage includes the following services:</strong></td>
</tr>
<tr>
<td></td>
<td>- Pneumonia vaccine</td>
</tr>
<tr>
<td></td>
<td>- Flu shots, once a year, in the fall or winter</td>
</tr>
<tr>
<td></td>
<td>- Hepatitis B vaccine if you the member is at high or intermediate risk of getting hepatitis B</td>
</tr>
<tr>
<td></td>
<td>- Other vaccines if the member is at risk and they meet Medicare Part B coverage rules</td>
</tr>
<tr>
<td></td>
<td>Coverage also includes other vaccines that meet the Medicare Part D coverage rules.</td>
</tr>
</tbody>
</table>
### Covered Services

<table>
<thead>
<tr>
<th>In-Home Supportive Services (IHSS)</th>
<th>Coverage is provided so that the member can remain safely in their own home. The types of IHSS which can be authorized through the County Department of Social Services are:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- Housecleaning</td>
</tr>
<tr>
<td></td>
<td>- Meal preparation</td>
</tr>
<tr>
<td></td>
<td>- Laundry</td>
</tr>
<tr>
<td></td>
<td>- Grocery shopping</td>
</tr>
<tr>
<td></td>
<td>- Personal care services (such as bowel and bladder care, bathing, grooming, and paramedical services)</td>
</tr>
<tr>
<td></td>
<td>- Accompaniment to medical appointments</td>
</tr>
<tr>
<td></td>
<td>- Protective supervision for the mentally impaired</td>
</tr>
</tbody>
</table>

*To qualify for IHSS, a member must be aged, blind, or disabled and, in most cases, have income below the level to qualify for the Supplemental Security Income/State Supplementary Program.*

If eligible, you may receive up to 283 hours of IHSS every month if approved by your county social worker.
## Covered Services

<table>
<thead>
<tr>
<th>Inpatient hospital care</th>
<th>Coverage includes following services, and maybe other services not listed here:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Semi-private room (or a private room if it is medically necessary)</td>
</tr>
<tr>
<td></td>
<td>• Meals, including special diets</td>
</tr>
<tr>
<td></td>
<td>• Regular nursing services</td>
</tr>
<tr>
<td></td>
<td>• Costs of special care units, such as intensive care or coronary care units</td>
</tr>
<tr>
<td></td>
<td>• Drugs and medications</td>
</tr>
<tr>
<td></td>
<td>• Lab tests</td>
</tr>
<tr>
<td></td>
<td>• X-rays and other radiology services</td>
</tr>
<tr>
<td></td>
<td>• Needed surgical and medical supplies</td>
</tr>
<tr>
<td></td>
<td>• Appliances, such as wheelchairs</td>
</tr>
<tr>
<td></td>
<td>• Operating and recovery room services</td>
</tr>
<tr>
<td></td>
<td>• Physical, occupational, and speech therapy</td>
</tr>
<tr>
<td></td>
<td>• Inpatient substance abuse services</td>
</tr>
<tr>
<td></td>
<td>• In some cases, the following types of transplants:</td>
</tr>
<tr>
<td></td>
<td>corneal, kidney, kidney/pancreatic, heart, liver, lung, heart/lung, bone marrow,</td>
</tr>
<tr>
<td></td>
<td>stem cell, and intestinal/multivisceral.</td>
</tr>
<tr>
<td>Covered Services</td>
<td></td>
</tr>
<tr>
<td>-----------------</td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient hospital care (continued)</strong></td>
<td>If a member needs a transplant, a Medicare-approved transplant center will review the case and decide whether the member is a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Medicare rate, then the member can get their transplant services locally or at a distant location outside the service area. If Anthem Blue Cross Cal MediConnect Plan provides transplant services at a distant location outside the service area and the member chooses to get their transplant there, Anthem will arrange or pay for lodging and travel costs for the member and one other person.</td>
</tr>
<tr>
<td></td>
<td>- Blood, including storage and administration</td>
</tr>
<tr>
<td></td>
<td>- Physician services</td>
</tr>
<tr>
<td><strong>Inpatient mental health care</strong></td>
<td>Coverage includes mental health care services that require a hospital stay.</td>
</tr>
<tr>
<td></td>
<td>- Coverage includes inpatient services in a freestanding psychiatric hospital for the first 190 days. After that, the local county mental health agency will pay for inpatient psychiatric services that are medically necessary. Authorization for care beyond the 190 days will be coordinated with the local county mental health agency.</td>
</tr>
<tr>
<td></td>
<td>- The 190-day limit does not apply to inpatient mental health services provided in a psychiatric unit of a general hospital.</td>
</tr>
<tr>
<td></td>
<td>- Members 65 years or older, Anthem will cover services received in an Institute for Mental Diseases (IMD).</td>
</tr>
</tbody>
</table>
## Covered Services

<table>
<thead>
<tr>
<th>Inpatient services covered during a non-covered inpatient stay</th>
<th>Inpatient stays that are not reasonable and needed will be denied.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>In some cases coverage for services obtained while the member is admitted in the hospital or a nursing facility will be covered. Coverage includes the following services, and maybe other services not listed here:</td>
</tr>
<tr>
<td></td>
<td>▪ Doctor services</td>
</tr>
<tr>
<td></td>
<td>▪ Diagnostic tests, like lab tests</td>
</tr>
<tr>
<td></td>
<td>▪ X-ray, radium, and isotope therapy, including technician materials and services</td>
</tr>
<tr>
<td></td>
<td>▪ Surgical dressings</td>
</tr>
<tr>
<td></td>
<td>▪ Splints, casts, and other devices used for fractures and dislocations</td>
</tr>
<tr>
<td></td>
<td>▪ Prosthetics and orthotic devices, other than dental, including replacement or repairs of such devices. These are devices that:</td>
</tr>
<tr>
<td></td>
<td>▪ Replace all or part of an internal body organ (including contiguous tissue), or</td>
</tr>
<tr>
<td></td>
<td>▪ Replace all or part of the function of an inoperable or malfunctioning internal body organ.</td>
</tr>
<tr>
<td></td>
<td>▪ Leg, arm, back, and neck braces, trusses, and artificial legs, arms, and eyes. This includes adjustments, repairs, and replacements needed because of breakage, wear, loss, or a change in the patient’s condition</td>
</tr>
<tr>
<td></td>
<td>▪ Physical therapy, speech therapy, and occupational therapy</td>
</tr>
</tbody>
</table>
## Covered Services

**Kidney disease services and supplies**

Coverage includes the following services:

- Kidney disease education services to teach kidney care and help members make good decisions about their care. Members must have stage IV chronic kidney disease, must refer be referred by their physician. Coverage includes up to six sessions of kidney disease education services.

- Outpatient dialysis treatments, including dialysis treatments when temporarily out of the service area.

- Inpatient dialysis treatments if the member is admitted as an inpatient to a hospital for special care.

- Self-dialysis training, including training for the member and anyone helping the member with home dialysis treatments.

- Home dialysis equipment and supplies.

- Certain home support services, such as necessary visits by trained dialysis workers to check on home dialysis, to help in emergencies, and to check dialysis equipment and water supply.
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Medical nutrition therapy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Coverage for members with diabetes or kidney disease without dialysis. It is also for</td>
</tr>
<tr>
<td></td>
<td>after a kidney transplant when referred by your doctor.</td>
</tr>
<tr>
<td></td>
<td>Coverage includes three hours of one-on-one counseling services during the first year that</td>
</tr>
<tr>
<td></td>
<td>the member receives medical nutrition therapy services under Medicare. (This includes our</td>
</tr>
<tr>
<td></td>
<td>plan, any other Medicare Advantage plan, or Medicare.) Up to 10 hours of initial outpatient</td>
</tr>
<tr>
<td></td>
<td>diabetes self-management training is covered in a continuous 12-month period, with up to</td>
</tr>
<tr>
<td></td>
<td>2 hours of follow-up training each subsequent calendar year following the completion of the</td>
</tr>
<tr>
<td></td>
<td>full 10 hours of initial training. Training may be done in any combination of 1/2 hour</td>
</tr>
<tr>
<td></td>
<td>increments. A physician must prescribe these services and renew the referral each year if</td>
</tr>
<tr>
<td></td>
<td>your treatment is needed in the next calendar year.</td>
</tr>
</tbody>
</table>
| Medicare Part B prescription drugs | These drugs are covered under Part B of Medicare. Anthem Blue Cross Cal MediConnect Plan will pay for the following drugs:  
- Injected or infused while provided by a physician, hospital outpatient, or ambulatory surgery center services  
- Drugs taken using durable medical equipment (such as nebulizers) that were authorized by the plan  
- Clotting factors – self-injection for members with hemophilia  
- Immunosuppressive drugs, if member is enrolled in Medicare Part A at the time of the organ transplant  
- Osteoporosis drugs that are injected. These drugs are paid for if member is homebound, has a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot inject the drug themselves  
- Antigens  
- Certain oral anti-cancer drugs and anti-nausea drugs  
- Certain drugs for home dialysis, including heparin, the antidote for heparin (when medically needed), topical anesthetics, and erythropoiesis-stimulating agents (such as, Procrit®, Aranesp®)  
- IV immune globulin for the home treatment of primary immune deficiency diseases |
### Covered Services

| Multi-Purpose Senior Services Program (MSSP) | MSSP is a case management program that provides Home and Community-Based Services (HCBS) to Medi-Cal eligible individuals. To be eligible, a member must be 65 years of age or older, live within a site's service area, be able to be served within MSSP's cost limitations, be appropriate for care management services, currently eligible for Medi-Cal, and certified or certifiable for placement in a nursing facility. MSSP services include:  
- Adult Day Care / Support Center  
- Housing Assistance  
- Chore and Personal Care Assistance  
- Protective Supervision  
- Care Management  
- Respite  
- Transportation  
- Meal Services  
- Social Services  
- Communications Services  
This benefit is covered up to $4,285 per year. |

---
## Covered Services

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Description</th>
</tr>
</thead>
</table>
| **Non-emergency medical transportation** | This benefit allows for transportation that is the most cost effective and accessible. This can include: ambulance, litter van, wheelchair van medical transportation services, and coordinating with para transit.  
The forms of transportation are authorized when:  
- Medical and/or physical condition does not allow the member to travel by bus, passenger car, taxicab, or another form of public or private transportation, and  
- Transportation is required for the purpose of obtaining needed medical care.  
Depending on the service, prior authorization may be required. |
| **Non-medical transportation**               | This benefit allows for transportation to medical services by passenger car, taxi, or other forms of public/private transportation.  
Members will have access to 30 one-way trips per year.  
This benefit does not limit your non-emergency medical transportation benefit. |
<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing facility care</strong></td>
</tr>
<tr>
<td>A nursing facility (NF) is a place that provides care for members who cannot get care at home but who do not need to be in a hospital. Coverage includes, but are not limited to, the following:</td>
</tr>
<tr>
<td>- Semiprivate room (or a private room if it is medically needed)</td>
</tr>
<tr>
<td>- Meals, including special diets</td>
</tr>
<tr>
<td>- Nursing services</td>
</tr>
<tr>
<td>- Physical therapy, occupational therapy, and speech therapy</td>
</tr>
<tr>
<td>- Drugs given to the member as part of your plan of care. (This includes substances that are naturally present in the body, such as blood-clotting factors.)</td>
</tr>
<tr>
<td>- Blood, including storage and administration</td>
</tr>
<tr>
<td>- Medical and surgical supplies usually given by nursing facilities</td>
</tr>
<tr>
<td>- Lab tests usually given by nursing facilities</td>
</tr>
<tr>
<td>- X-rays and other radiology services usually given by nursing facilities</td>
</tr>
<tr>
<td>- Use of appliances, such as wheelchairs usually given by nursing facilities</td>
</tr>
<tr>
<td>- Physician/practitioner services</td>
</tr>
<tr>
<td>- Durable medical equipment</td>
</tr>
<tr>
<td>- Dental services, including dentures</td>
</tr>
<tr>
<td>- Vision benefits</td>
</tr>
<tr>
<td>- Hearing exams</td>
</tr>
<tr>
<td>- Chiropractic care</td>
</tr>
<tr>
<td>- Podiatry services</td>
</tr>
</tbody>
</table>
## Covered Services

<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Nursing facility care (continued)</strong></td>
<td>Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept Anthem’s amounts for payment:</td>
</tr>
<tr>
<td></td>
<td>- A nursing home or continuing care retirement community where the member was living right before being admitted to the hospital (as long as it provides nursing facility care).</td>
</tr>
<tr>
<td></td>
<td>- A nursing facility where a member’s spouse is living at the time the members is discharged from the hospital.</td>
</tr>
<tr>
<td><strong>Obesity screening and therapy to keep weight down</strong></td>
<td>Coverage available for members with a body mass index of 30 or more includes counseling to help the member lose weight. Member must get the counseling in a primary care setting and be managed within the member’s full prevention plan.</td>
</tr>
<tr>
<td><strong>Out-of-area dialysis services</strong></td>
<td>Members may obtain medically necessary dialysis services from any qualified Provider when they are temporarily absent from the Anthem Blue Cross Cal MediConnect service area and cannot reasonably access contracted Anthem Blue Cross Cal MediConnect dialysis Providers. Members can obtain dialysis services without precertification or notification when outside of the Anthem Blue Cross Cal MediConnect service area. We suggest Members advise Anthem Blue Cross if they will temporarily be out of the service area, so a qualified dialysis Provider may be recommended.</td>
</tr>
<tr>
<td>Covered Services</td>
<td></td>
</tr>
<tr>
<td>------------------------------------------------------</td>
<td></td>
</tr>
</tbody>
</table>
| **Outpatient diagnostic tests and therapeutic services and supplies** | Coverage includes the following services, and maybe other services not listed here:  
  - X-rays  
  - Radiation (radium and isotope) therapy, including technician materials and supplies  
  - Surgical supplies, such as dressings  
  - Splints, casts, and other devices used for fractures and dislocations  
  - Lab tests  
  - Blood, including storage and administration  
  - Other outpatient diagnostic tests |
| **Outpatient hospital services**                     | Coverage available for medically needed services available in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.  
  Coverage includes the following services, and maybe other services not listed here:  
  - Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery  
  - Labs and diagnostic tests billed by the hospital  
  - Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be needed without it  
  - X-rays and other radiology services billed by the hospital  
  - Medical supplies, such as splints and casts  
  - Some screenings and preventive services  
  - Some drugs that you can’t give yourself |
<table>
<thead>
<tr>
<th>Covered Services</th>
<th>Coverage includes mental health services provided by:</th>
</tr>
</thead>
</table>
| **Outpatient mental health care** | - A state-licensed psychiatrist or doctor  
- A clinical psychologist  
- A clinical social worker  
- A clinical nurse specialist  
- A nurse practitioner  
- A physician assistant  
- Any other Medicare-qualified mental health care professional as allowed under applicable state laws |
|                   | Coverage includes the following services, and maybe other services not listed here: |
|                   | - Clinic services  
- Day treatment  
- Psychosocial rehab services  
- Partial hospitalization/Intensive outpatient programs  
- Individual and group mental health evaluation and treatment  
- Psychological testing when clinically indicated to evaluate a mental health outcome  
- Outpatient services for the purposes of monitoring drug therapy  
- Outpatient laboratory, drugs, supplies and supplements  
- Psychiatric consultation |

**Outpatient rehabilitation services**

Coverage includes physical therapy, occupational therapy, and speech therapy.

Members can get outpatient rehabilitation services from hospital outpatient departments, independent therapist offices, comprehensive outpatient rehabilitation facilities (CORFs), and other facilities.
<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
</table>
| **Outpatient substance abuse services** | Coverage for following services, and maybe other services not listed here:  
  ▪ Alcohol misuse screening and counseling  
  ▪ Treatment of drug abuse  
  ▪ Group or individual counseling by a qualified clinician  
  ▪ Sub-acute detoxification in a residential addiction program  
  ▪ Alcohol and/or drug services in an intensive outpatient treatment center  
  ▪ Extended release Naltrexone (vivitrol) treatment |
| **Outpatient surgery**                | Coverage available for outpatient surgery and services at hospital outpatient facilities and ambulatory surgical centers. |
| **Partial hospitalization services** | Partial hospitalization is a structured program of active psychiatric treatment. It is offered in a hospital outpatient setting or by a community mental health center. It is more intense than the care a member gets in their doctor’s or therapist’s office. It can help keep members from having to stay in the hospital.  
  **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only in a hospital outpatient setting. |
### Covered Services

<table>
<thead>
<tr>
<th><strong>Physician/provider services, including doctor’s office visits</strong></th>
<th>Coverage includes the following services:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Medically necessary health care or surgery services given in places such as:</td>
</tr>
<tr>
<td></td>
<td>    Physician’s office</td>
</tr>
<tr>
<td></td>
<td>    Certified ambulatory surgical center</td>
</tr>
<tr>
<td></td>
<td>    Hospital outpatient department</td>
</tr>
<tr>
<td></td>
<td>▪ Consultation, diagnosis, and treatment by a specialist</td>
</tr>
<tr>
<td></td>
<td>▪ Basic hearing and balance exams given by a primary care provider or specialist</td>
</tr>
<tr>
<td></td>
<td>▪ Some telehealth services, including consultation, diagnosis, and treatment by a physician or practitioner for members in rural areas or other places approved by Medicare. Pre-authorization required.</td>
</tr>
<tr>
<td></td>
<td>▪ Second opinion before a medical procedure</td>
</tr>
<tr>
<td></td>
<td>▪ Non-routine dental care. Covered services are limited to:</td>
</tr>
<tr>
<td></td>
<td>    Surgery of the jaw or related structures</td>
</tr>
<tr>
<td></td>
<td>    Setting fractures of the jaw or facial bones</td>
</tr>
<tr>
<td></td>
<td>    Pulling teeth before radiation treatments of neoplastic cancer</td>
</tr>
<tr>
<td></td>
<td>    Services that would be covered when provided by a physician</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Podiatry services</strong></th>
<th>Coverage includes the following services:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>▪ Diagnosis and medical or surgical treatment of injuries and diseases of the foot (such as hammer toe or heel spurs)</td>
</tr>
<tr>
<td></td>
<td>▪ Routine foot care for members with conditions affecting the legs, such as diabetes</td>
</tr>
</tbody>
</table>
## Covered Services

### Prescription Drug Coverage

The **Anthem Blue Cross Cal MediConnect Plan** follows the following Formulary Tier Structure:

- **Tier 1** – Medicare Part D Preferred Brand / Generic drugs with $0 copay
- **Tier 2** – Medicare Part D Non-Preferred Brand / Generic drugs – low income subsidies (LIS) copay applies
- **Tier 3** – State Medicaid Rx Generic drugs and Brand named drugs with $0 copay
- **Tier 4** – State Medicaid Over the Counter (OTC) $0 copay

### Prescription Drugs

Prescription drugs are only available by prescription, are used or sold in the United States and must be used for medically accepted indications. Prescription drugs covered by **Anthem Blue Cross Cal MediConnect** are listed in the **Anthem Blue Cross Cal MediConnect** formulary. The formulary includes all generic drugs covered under the program, as well as many brand-name drugs, non-preferred brands and specialty drugs. One can view a copy of the formulary on the [Anthem Blue Cross](https://www.anthem.com/CA) website at www.anthem.com/CA or request a copy from the Provider Relations department. Some of these drugs have precertification or step-therapy requirements or quantity limits. Providers may request authorization for a drug or coverage of a drug not on the formulary by contacting the Pharmacy at 1-855-817-5786 or via fax at 1-800-359-5781.

**Anthem Blue Cross Cal MediConnect** Members should obtain covered drugs from a network pharmacy pursuant to a physician’s prescription.

Pharmacy claims are processed by Express Scripts Inc. (ESI), the **Anthem Blue Cross Cal MediConnect** pharmacy benefit management vendor. ESI services also include home infusion, LTC pharmacy and mail-order pharmacy. More information on these services can be obtained by contacting the Pharmacy department at the number listed above.
### Covered Services

| Prescription Drugs by Mail Order | Members can use the mail-order service to fill prescriptions for maintenance drugs (i.e., drugs taken on a regular basis for a chronic or long-term medical condition). For mail-order prescriptions, the physician must write on the maintenance drug prescription whether it is for a 31-, 62- or 93-day supply. When mailing in a prescription to the mail-order service for the first time, the Member should allow up to two weeks for the prescription to be filled. For refills of the same prescription, Members should allow up to two weeks for mailing and processing.

If a Member runs out of a medication before receiving a new supply from the mail-order pharmacy, please call the Pharmacy at 1-855-817-5786. They will assist with obtaining an emergency supply of the Member’s medication until he or she receives the new mail-order supply.

Members are not required to use mail-order prescription drug services to obtain an extended supply of maintenance medications. Members also have the option of using a retail pharmacy in the **Anthem Blue Cross Cal MediConnect** network to obtain their maintenance medications. Some retail pharmacies may agree to accept the mail-order reimbursement rate for an extended supply of medication, which may result in no out-of-pocket payment difference to the Member. |
### Covered Services

<table>
<thead>
<tr>
<th>Preventative services</th>
<th>The following preventive services are offered to Members with no Member copayment or cost sharing:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Preventive visit</td>
</tr>
<tr>
<td></td>
<td>  - Annual physical examination (in addition to the Medicare preventive visits)</td>
</tr>
<tr>
<td></td>
<td>    - You may bill for one routine annual visit per year (e.g., 99385–99387, 99395–99397) with</td>
</tr>
<tr>
<td></td>
<td>      diagnosis code V70.0</td>
</tr>
<tr>
<td></td>
<td>  - Welcome to Medicare exam</td>
</tr>
<tr>
<td></td>
<td>  - Annual wellness exam</td>
</tr>
<tr>
<td></td>
<td>• Bone mass measurements</td>
</tr>
<tr>
<td></td>
<td>• Colorectal screening</td>
</tr>
<tr>
<td></td>
<td>• Diabetic monitoring training</td>
</tr>
<tr>
<td></td>
<td>• Cardiovascular disease testing</td>
</tr>
<tr>
<td></td>
<td>• Mammography screening</td>
</tr>
<tr>
<td></td>
<td>• Pap smear, pelvic exams and clinical breast exams</td>
</tr>
<tr>
<td></td>
<td>• Prostate cancer screening exams</td>
</tr>
<tr>
<td></td>
<td>• Abdominal aortic aneurysm screening</td>
</tr>
<tr>
<td></td>
<td>• Diabetes screening</td>
</tr>
<tr>
<td></td>
<td>• EKG screening</td>
</tr>
<tr>
<td></td>
<td>• Flu shots</td>
</tr>
<tr>
<td></td>
<td>• Glaucoma tests</td>
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<tr>
<td></td>
<td>• Hepatitis B shots</td>
</tr>
<tr>
<td></td>
<td>• HIV screenings</td>
</tr>
<tr>
<td></td>
<td>• Medical nutrition therapy services</td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal shots</td>
</tr>
<tr>
<td></td>
<td>• Smoking cessation (counseling to stop smoking)</td>
</tr>
<tr>
<td></td>
<td>• Depression screening</td>
</tr>
<tr>
<td>Prostate cancer screening exams</td>
<td>Coverage for men age 50 and older, includes the following services once every 12 months:</td>
</tr>
<tr>
<td></td>
<td>  • A digital rectal exam</td>
</tr>
<tr>
<td></td>
<td>  • A prostate specific antigen (PSA) test</td>
</tr>
</tbody>
</table>
## Covered Services

| Prosthetic devices and related supplies | Coverage includes the following prosthetic devices, and maybe other devices not listed here:  
- Colostomy bags and supplies related to colostomy care  
- Pacemakers  
- Braces  
- Prosthetic shoes  
- Artificial arms and legs  
- Breast prostheses (including a surgical brassiere after a mastectomy)  
- Incontinence cream and diapers  
Coverage also includes some supplies related to prosthetic devices, including repair or replacement of prosthetic devices.  
**Exclusions - Prosthetic dental devices.** |
| Pulmonary rehabilitation services | Coverage includes pulmonary rehabilitation programs for members who have moderate to very severe chronic obstructive pulmonary disease (COPD). Members must have a referral or an order for pulmonary rehabilitation from the doctor or provider treating the COPD.  
Coverage also includes respiratory services for ventilator-dependent patients. |
| Sexually transmitted infections (STIs) screening and counseling | Coverage includes screenings for chlamydia, gonorrhea, syphilis, and hepatitis B. These screenings are covered for pregnant members and for some members who are at increased risk for an STI. A primary care provider must order the tests. Coverage is limited to once every 12 months or at certain times during pregnancy. |
## Covered Services

### Skilled nursing facility care

Coverage includes the following services, and maybe other services not listed here:

- A semi-private room, or a private room if it is medically needed
- Meals, including special diets
- Nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs you get as part of your plan of care, including substances that are naturally in the body, such as blood-clotting factors
- Blood, including storage and administration
- Medical and surgical supplies given by nursing facilities
- Lab tests given by nursing facilities
- X-rays and other radiology services given by nursing facilities
- Appliances, such as wheelchairs, usually given by nursing facilities
- Physician/provider services

Members will usually get care from network facilities. However, members may be able to get care from a facility not in our network. Members can get care from the following places if they accept our plan’s amounts for payment:

- A nursing home or continuing care retirement community where a member lived before they went to the hospital (as long as it provides nursing facility care)
- A nursing facility where the member’s spouse lives at the time you leave the hospital
## Covered Services

<table>
<thead>
<tr>
<th>Supplemental benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Supplemental benefits are those benefits in addition to the basic Medicare services offered through Medicare Part A and B and the California Medi-Cal program. <strong>Anthem Blue Cross</strong> offers limited supplemental benefits to covered Members as outlined in the Summary of Benefits documents. Please refer to the Summary of Benefits for specific supplemental benefits being offered.</td>
</tr>
</tbody>
</table>

Below is a list of supplemental benefits we offer. Please refer to the Summary of Benefits documents for details on which plans cover certain supplemental benefits.

- Routine foot and nail care up to 4 visits per year
- Supplemental routine eye examinations once yearly
- Up to $100 yearly for eyeglasses or contact lenses
- Routine hearing examinations and hearing aids
- Dental examinations and cleanings
- Telephonic physician consultation services available through the Nurse HelpLine 24 hours a day, seven days a week
- Monthly gym membership is through Silver Sneakers® Fitness Program

Although not normally covered under the Medicare program, the following items are covered under the Medicaid component of the **Anthem Blue Cross Cal MediConnect Plan**.

- Generic drugs covered in the Part D coverage gap with the applicable generic prescription
- Nonemergency transportation

Details for Provider billing for rendered services are available on the **Anthem Blue Cross** Provider website or by calling Provider Services at **Anthem Blue Cross Cal MediConnect Customer Care** at **1-855-817-5786**.
<table>
<thead>
<tr>
<th>Covered Services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent care</strong></td>
</tr>
</tbody>
</table>

Urgent care is care given to treat:
- A non-emergency, or
- A sudden medical illness, or
- An injury, or
- A condition that needs care right away.

Members requiring urgent care, should first try to get it from a network provider. However, you can use out-of-network providers when you cannot get to a network provider.

Only emergency services are covered outside the U.S.
## Covered Services

### Vision care

Anthem Blue Cross Cal MediConnect members will receive routine vision services through VSP. Members will have vision benefits which include annual routine eye exams and glasses. Coverage includes the following services:

- One routine eye exam every year; and
- Up to $200 for eyeglasses (frames and lenses) or up to $200 for contact lenses every two years.

Coverage also includes outpatient doctor services for the diagnosis and treatment of diseases and injuries of the eye. This includes treatment for age-related macular degeneration.

For members at high risk of glaucoma, coverage includes one glaucoma screening each year. Members at high risk of glaucoma include:

- Members with a family history of glaucoma
- Members with diabetes
- African-Americans who are age 50 and older

Coverage includes one pair of glasses or contact lenses after each cataract surgery when the doctor inserts an intraocular lens. Coverage also includes corrective lenses, and frames, and replacements if a member needs them after a cataract removal without a lens implant.
## Covered Services

<table>
<thead>
<tr>
<th>“Welcome to Medicare” Preventive Visit</th>
<th>Coverage includes the one-time “Welcome to Medicare” preventive visit. The visit includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>- A review of the members health,</td>
</tr>
<tr>
<td></td>
<td>- Education and counseling about the preventive services a member needs (including screenings and shots), and</td>
</tr>
<tr>
<td></td>
<td>- Referrals for other care if needed</td>
</tr>
<tr>
<td><strong>Important:</strong> Anthem covers the “Welcome to Medicare” preventive visit only during the first 12 months that a has Medicare Part B.</td>
<td></td>
</tr>
</tbody>
</table>

## Health Care Benefits

### Pharmacy - Formulary Exceptions

If a prescription drug is not listed in the Anthem Blue Cross Cal MediConnect formulary, please check the updated formulary on the Anthem Blue Cross website. The website formulary is updated frequently with any changes. In addition, Providers may contact the Anthem Blue Cross Cal MediConnect Pharmacy Department to be sure a drug is covered. If the Pharmacy Department confirms the drug is not on the formulary, there are two options:

- The prescribing physician can prescribe another drug that is covered on the formulary.
- The patient or prescribing physician may ask Anthem Blue Cross to make an exception (a type of coverage determination) to cover the non-formulary drug. If the Member pays out-of-pocket for a non-formulary drug and requests an exception Anthem Blue Cross approves, Anthem Blue Cross will reimburse the Member. If the exception is not approved, the Member may appeal the plan’s denial. See the Member Liability Appeals section for more information on requesting exceptions and appeals.

In some cases, Anthem Blue Cross will contact a Member who is taking a drug that is not on the formulary. Anthem Blue Cross will give the Member the names of covered drugs used to treat his or her condition and encourage the Member to ask his or her physician if any of those drugs would be appropriate options for treatment. Also, Members who recently joined the Anthem Blue Cross Cal MediConnect may be able to get a temporary supply of a drug they are taking if the drug is not on the Anthem Blue Cross Cal MediConnect formulary.
Health Care Benefits
Pharmacy - Transition Policy

New Members in **Anthem Blue Cross Cal MediConnect Plan** may be taking drugs that are not on the formulary or that are subject to certain restrictions, such as precertification or step-therapy. Current Members may also be affected by changes in the formulary from one year to the next. Members are encouraged to talk to their Providers to decide if they should switch to a different drug **Anthem Blue Cross** covers or request a formulary exception in order to get coverage for the drug (as described above).

During the period of time Members are talking to their Providers to determine the right course of action, **Anthem Blue Cross** may provide a temporary supply of the non-formulary drug if those Members need a refill for the drug during the first 90 days of new membership in the **Anthem Blue Cross Cal MediConnect Plan**. For current Members affected by a formulary change from one year to the next, **Anthem Blue Cross** will provide a temporary supply of the non-formulary drug for Members needing a refill for the drug during the first 90 days of the new plan year.

When a Member goes to an **Anthem Blue Cross Cal MediConnect** network pharmacy and **Anthem Blue Cross** provides a temporary supply of a drug that is not on the formulary or that has coverage restrictions or limits, **Anthem Blue Cross** will cover at least a one-time, 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, **Anthem Blue Cross** generally will not pay for these drugs again as part of the transition policy. **Anthem Blue Cross** will provide the Member with a written notice after it covers a temporary supply. The notice will explain the steps the Member can take to request an exception and the way to work with the prescribing physician to decide if switching to an appropriate formulary drug is feasible.

If a new Member is a resident of a long-term care facility (like a nursing home), **Anthem Blue Cross** will cover a temporary 31-day transition supply (unless the prescription is written for fewer days). If necessary, **Anthem Blue Cross** will cover more than one refill of these drugs during the first 90 days a Member is enrolled in our plan. If the Member has been enrolled in the plan for more than 90 days and needs a drug that is not on the formulary or is subject to other restrictions such as step therapy or dosage limits, **Anthem Blue Cross** will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new Member requests a formulary exception.

This policy also applies to current Members who experience a change in the level of their care. For example, if a Member leaves the hospital and enters a long-term care facility or leaves hospice status and reverts back to standard care, the Member may receive a temporary transition supply of the non-formulary drug for up to 31 days, unless the prescription is written for fewer days.
CHAPTER 5: LONG TERM SERVICES AND SUPPORTS (LTSS)

Long Term Services and Supports
Overview

Anthem covers a wide variety of Long Term Services and Supports (LTSS) that help elderly individuals and/or individuals with disabilities with their daily needs for assistance and improve the quality of their lives.

Examples include assistance with bathing, dressing and other basic activities of daily life and self-care, as well as support for everyday tasks such as laundry, shopping and transportation. LTSS are provided over an extended period, predominantly in the homes and communities, but also in facility-based settings such as nursing facilities.

These services fall into four categories and are defined as follows:
- In Home Support Services (IHSS)
- Community-Based Adult Services (CBAS)
- Multipurpose Senior Services Program (MSSP)
- Long Term Services and Supports/Skilled Nursing Facility

Long Term Services and Supports
In-Home Support Services (IHSS)

This California state program provides in-home care to the elderly and persons with disabilities allowing them to safely remain in their homes.

Eligibility

To qualify for IHSS, an enrollee must be aged, blind or disabled and in most cases, have income below the level to qualify for SSI/State Supplementary Program.

County Public Authority

The County Public Authority social worker is responsible for assessing, approving and authorizing hours, services and tasks based on the needs of the beneficiary. They are responsible for screening and enrolling service providers, conducting criminal background checks, conducting Provider orientation and retaining enrollment documentation. In addition, they maintain a Provider registry and can provide assistance in finding eligible Providers and perform quality assurance activities.

Types of services provided include:
- Domestic and Related Services (house cleaning/chores, meal preparation & clean-up, laundry, grocery shopping, heavy cleaning)
- Personal Care (i.e., bathing & grooming, dressing, feeding)
- Paramedical Services (i.e., administration of medication, puncturing skin, range of motion exercises)
- Other Services (i.e., accompaniment to medical appointments, yard hazard abatement, protective supervision)
Eligible for In-Home Supportive Services (IHSS)

All IHSS beneficiaries must:

- Be a California resident and a U.S. citizen/legal resident, and be living in their own home
- Be eligible to receive Supplemental Security Income/State Supplemental Payment (SSI/SSP) or Medi-Cal benefits
- Be 65 years of age or older, legally blind or disabled by Social Security standards
- Submit a health care certification form (SOC 873) from a licensed health care professional indicating that they need assistance to stay living at home.

IHSS- Referral – How a beneficiary or provider access IHSS

The county department of Public Social Services (DPSS) determines eligibility and hours of service. The beneficiary can apply to IHSS by calling 1-888-944-IHSS (inside Los Angeles County) or 1-213-744-4477 (Outside Los Angeles County). The Personal Assistance Service Council (PASC) assists beneficiaries with finding homecare workers, and providers other support services for IHSS beneficiaries. They can be reached at 1-877-565-4477.

Long Term Services and Supports

IHSS Member Control/Responsibility

IHSS allows the Member to self-direct their care by being able to hire, fire and manage their homecare workers. A trusted friend or family member could become screened, qualified and compensated as a Member’s IHSS Provider/Caregiver. The Member could also elect to involve the IHSS Provider/Caregiver as a member of their Care Team. County agencies administering the IHSS program will maintain their current roles and Anthem will not be able to reduce the IHSS hours authorized by the county. If a member or provider needs assistance they can contact their Anthem Care Coordinator.
Long Term Services and Supports

Community Based Adult Services (CBAS)

A facility-based outpatient program serving individuals 18 years old and over who have functional impairment that puts them at risk for institutional care. The program delivers the following adult day care services:

- Skilled nursing
- Social services
- Physical and Occupational Therapies
- Personal care
- Family/caregiver training and support
- Meals
- Transportation

The primary objectives of the CBAS program are to: restore and maintain optimal capacity for self-care to the elderly or other adults with physical and mental disabilities and delay or prevent inappropriate or personally undesirable institutionalization in long-term care facilities.

Long Term Services and Supports

CBAS - Eligibility

CBAS services may be provided to Medi-Cal beneficiaries over 18 years of age who:

- Meet Nursing Facility A or B Requirements
- Have organic/Acquired or Traumatic Brain Injury and/or Chronic Mental Health conditions
- Have Alzheimer’s disease or other dementia
- Have Mild Cognitive Impairment
- Have a Developmental Disability

Anthem conducts an assessment to determine final program eligibility.

CBAS Centers still determine levels of service after authorization. Those currently enrolled in the CBAS program will remain in the program as long as they are enrolled in a Medi-Cal health plan. CBAS providers continue to follow the already established policies and procedures.

Long Term Services and Supports

CBAS - Referral

To receive CBAS services, a beneficiary must first be enrolled in a Medi-Cal health plan. To begin the referral process please contact Anthem’s Member Services Department to begin the process. See the contact section of the manual for the contact number.

CBAS providers must obtain an authorization from Anthem.
Long Term Services and Supports

Multipurpose Senior Services Program

The Multipurpose Senior Services Program (MSSP) is California 1915c Home and Community Based Services (HCBS) waiver program that operates as an alternative to nursing home placement for those 65 years of age and over with disabilities. The MSSP is an intensive case management program that coordinates social and health care services in the community for those wishing to remain in the community and delay or prevent institutional placement.

Types of services provided:

- Case Management
- Personal Care services
- Respite Care (in-home and out-of-home)
- Environmental Accessibility Adaptations
- Housing Assistance/Minor Home Repair
- Transportation
- Chore Services
- Personal Emergency Response System (PERS)/Communication Device
- Adult Day Care/Support Center/Health Care
- Protective Supervision
- Meal Services (Congregate/Home Delivered)
- Social Reassurance/Therapeutic Counseling
- Money Management
- Translation/Interpretation

MSSPs work closely with local organizations and agencies that provide Long Term Services & Supports (LTSS) and home and community based services.

Long Term Services and Supports

MSSP – Referral

After the CCI begins, in order to receive MSSP services, a beneficiary must first be enrolled in a Medi-Cal health plan like Anthem. To begin the referral process for a beneficiary, please contact our Care Coordinators for assistance or Member Services Department. Contact numbers can be found in the contact section of this manual.

Long Term Services and Supports

MSSP Waiver Services

An MSSP provider may purchase MSSP Waiver Services when necessary to support the well-being of an Anthem member who is an MSSP Waiver Participant.
Prior to purchasing these services, MSSP providers must verify, and document all efforts to determine the availability of alternative resources (e.g., family, friends and other community resources) for the member.

Approved Purchased Waiver Services are listed and defined in the MSSP Provider Site Manual located on the California Department of Aging website at www.aging.ca.gov. To access the MSSP manual on this site, select Providers and Partners > Multipurpose Senior Services Program > MSSP Site Manual and Appendices.

MSSP providers may enter into contract with subcontractors and vendors to provide Purchased Waiver Services or directly purchase items through the use of a purchase order. Anthem requires MSSP providers to maintain written subcontractor/vendor agreements for the following minimum array of Purchased Waiver Services:

- Adult Day Support Center (ADSC) and Adult Day Care (ADC)
- Housing Assistance
- Supplemental Personal Care Services
- Care Management
- Respite Care
- Transportation
- Meal Services
- Protective Services
- Special Communications

MSSP subcontractors and vendors are bound by the following:

- All MSSP subcontractors and vendors must have the proper license, credentials, qualifications or experience to provide services to any Anthem member receiving MSSP services.
- All reimbursements must come from the MSSP provider with whom the subcontractor or vendor has a signed agreement.
- No MSSP subcontractor or vendor may seek any payment for MSSP services from any Anthem member or from Anthem itself.

MSSP providers are responsible for coordinating and tracking MSSP purchased Waiver Services for any Anthem member receiving MSSP services.

For information about how to submit claims for MSSP services, please see Reimbursement to Multipurpose Senior Services Program Providers at the end of this chapter.

For members under the MSSP waiver receiving a monthly payment, an authorization is not required.

For members on the waiting list in need of services, please contact Anthem for an authorization. An authorization will ensure there will be no issues when a claim is submitted for payment of covered benefits.
Long-Term Services and Supports

Transition and Discharge Planning

When long-term services and supports are necessary, Anthem works with the Provider and Member (or their designated representative) to plan the transition/discharge to an appropriate setting for extended services. These services can be delivered in a nonhospital facility such as:

- Nursing Facilities, Subacute Care Facilities (NF/SCF)
- Respite Care – In Home or Out of Home
- Home and Community Based Services (HCBS)
- Home health care program (i.e., home I.V. antibiotics)

When the Member and family together with the Provider identifies medically necessary and appropriate services for the Member, then Anthem will assist in providing a timely and effective plan that meets the Member’s needs and goals.

Responsibilities of the LTSS Provider

- Assisted living facilities and nursing homes must retain a copy of the Member’s Anthem plan of care on file with the member’s records.
- Assisted living facilities are required to promote and maintain a homelike environment and facilitate community integration.
- All facility-based Providers and home health agencies must notify an Anthem case manager within 24 hours when a Member dies, leaves the facility or moves to a new residence or moves outside the service area or state.
- LTSS Providers can participate in the Member’s Interdisciplinary Care Team (ICT) dependent on the Member’s need and preference.

Interactive Voice Response Requirements of Providers

The following Providers are required to have 24-hour service:

- Assisted living facilities /Services
- Emergency response systems
- Nursing homes/Skilled Nursing Facilities

Such Providers will provide advice and assess care as appropriate for each Member’s medical condition. Emergent conditions will be referred to the nearest emergency room.
Long-Term Services and Supports

Identifying and Verifying the Long-Term Care Member

Upon enrollment, we will send a welcome package to the Member. This package includes an introductory letter, a Member ID card and a Member Handbook. Each Anthem Member will identify himself or herself prior to receiving services by presenting an Anthem ID card, which includes a Member number. You can check Member eligibility online via the State of California using any of the following:

- Our 24/7 Automated Eligibility Voice System (AEVS) **1-800-546-2387**
- www.medi-cal.ca.gov/Eligibility/Login.asp

If you have questions regarding eligibility and or benefits, contact customer care at:

- **1-888-285-7801** (Inside L.A. County)
- **1-800-407-4627** (Outside of L.A. County)

Long-Term Services and Supports

Nursing Home Eligibility

Anthem will review the member’s eligibility and benefits to determine if a member qualifies for Nursing Facility placement. This review will include the initial Level of Care (LOC) (including custodial nursing home vs. Skilled Nursing Facility) conducted by the Anthem Authorization/Case Manager/Care Coordinator.

For members who reside in a nursing home, the care coordinator will complete the Health Risk Assessment within 60 days of plan enrollment via a face-to-face meeting. During this process, the care coordinator will ensure to incorporate Minimum Data Set 2.0 (MDS 2.0) into the Plan of Care.


Long-Term Services and Supports

Covered Health Services

Anthem provides the covered services listed below and will authorize these covered services. Any modification to covered services will be communicated through a Provider newsletter, Provider manual update and/or contractual amendment. The scope of benefits includes the following:

Home and Community Services

- Adult attendant services
- Adult day health center services
- Assisted living services
- Care management services
- Chore services
- Home-delivered meal services
- Homemaker services
- Nursing facility services
- Nutritional assessment/risk reduction services
- Occupational therapy
Consumable medical supply services
Environmental accessibility adaptation services
Escort services
Family training services
Financial assessment/risk reduction services

Personal care services
Personal emergency response system services
Physical therapy
Respiratory therapy
Respite care services
Speech therapy

**Long Term Services and Supports**

**Anthem Coordination**

The Anthem Coordination model promotes cross-functional collaboration in the development of Member service strategies. Members identified as waiver Members, high risk and/or with complex needs are enrolled into the service coordination program and are provided individualized services to support their behavioral, social, environmental, and functional and health needs. Service Coordinators accomplish this by screening, assessing, and developing targeted and tailored Member interventions while working collaboratively with the Member, practitioner, provider, caregiver and natural supports.

Since many Anthem Members have complex needs that require services from multiple Providers and systems, gaps may occur in the delivery system serving these Members. These gaps can create barriers to Members receiving optimal care. The Anthem service coordination model helps reduce these barriers by identifying the unmet needs of Members and assisting them to find solutions to those needs. This may involve coordination of care, assisting Members in accessing community based resources or any of a broad range of interventions designed to improve the quality of life and functionality of Members and to make efficient use of available health care and community based resources.

The scope of the Service Coordination Model includes but is not limited to:

- Annual assessments of characteristic and needs of Member populations and relevant sub-populations
- Initial and ongoing assessment
- Problem-based, comprehensive service planning, to include measurable prioritized goals and interventions tailored to the complexity level of the Member as determined by the initial and ongoing assessments.
- Coordination of care with PCPs and specialty Providers
- Providing a service coordination approach that is “Member-centric” and provide support, access, and education along the continuum of care
- Establishing a plan that is personalized to meet a Member’s specific needs and identifies: prioritized goals, time frames for reevaluation, resources to be utilized including the appropriate level of care, planning for continuity of care, and family participation
• Obtaining Member/family/caregiver input and level of participation in the creation of a service plan that includes the development of self-management strategies to increase the likelihood of improved health outcomes that may result in improved quality of life.

Long Term Services and Supports

Consumer Direction

Consumer direction is a process by which eligible home and community based services (HCBS) are delivered; it is not a service. Consumer direction affords Members the opportunity to have choice and control over how eligible HCBS are provided. The program also allows Members to have choice and control over who provides the services and how much workers are paid for providing care — up to a specified maximum amount established by California’s DHCS. Member participation in consumer direction of HCBS is voluntary. Members may elect to participate in or withdraw from consumer direction of HCBS at any time without affecting their enrollment.

Consumer direction is offered for Members who, through the needs assessment/reassessment process, are determined by Care Coordinators to need any service specified in DHCS rules and regulations as available for consumer direction. These services include, but are not limited to:

• Attendant/personal care
• in-home respite care

A service that is not specified in DHCS rules and regulations as available for consumer direction shall not be consumer-directed.

If a Member chooses not to direct his or her care, he or she will receive authorized HCBS through contract Providers. Members who participate in consumer direction of HCBS choose either to serve as the employer of record for their workers or to designate a representative to serve as the employer of record on his or her behalf. The Member must arrange for the provision of needed personal care and does not have the option of going without needed services.

Contact numbers for IHSS DPSS and PASC are in the contact section of the manual if we want to direct them to that.

Long Term Services and Supports

Discharge Planning

Anthem assists with discharge planning, either to the community or through a transfer to another facility, if the Member or responsible party so requests. If the Member or responsible party requests a discharge to the community, the Care/Service Coordinator will:

• Collaborate with the skilled nursing facility (SNF) Social Worker to convene a planning conference with the SNF staff to identify all potential needs in the community
• Facilitate a home visit to the residence where the Member intends to move to assess environment, durable medical equipment (DME) and other needs upon discharge
• Convene a discharge planning meeting with the Member and family, using the data complied through discussion with the SNF staff as well as home visit, to identify Member preferences and goals

• Involve and collaborate with community originations such as Community Developmental Disability Organizations (CDDOs), Centers for Independent Living (CILs) or Area Agencies on Aging (AAAs) in this process to assist Members as they transition to the community

• Finalize and initiate execution of the transition plan

Although our Member-centric approach is driven by the Member, the transition implementation is a joint effort between the SNF Social Worker and the Anthem Care Coordinator.

**Long Term Services and Supports**

**Medical and Nonmedical Absences**

Members are allowed up to seven days per confinement for reservation of a bed when a SNF, SNF/MH, or ICF/MR beneficiary leaves a facility and is admitted to an acute care facility when conditions under the reserve day regulations are met. To ensure accurate payment, the SNF, SNF/MH, or ICF/MR must bill hospital leave days consecutively beginning with the date of admission.

Members are allowed up to 21 days per admission for reservation of a bed when an SNF/MH resident leaves a facility and is admitted to one of the state mental hospitals, a private psychiatric hospital, or a psychiatric ward in an acute care hospital. To ensure accurate payment, the SNF/MH must bill psychiatric leave days consecutively, beginning with the date of admission.

If a beneficiary is not admitted to a hospital but goes to a hospital for observation purposes only, it is considered an approved nursing facility day and not a hospital or therapeutic reserve day.

In the event of a nonmedical absence from a SNF, providers will obtain an authorization with the status changes on the nursing home member and should bill the end hold/leave of absence Revenue code and accommodation code. A maximum of 18 home-leave days for SNFs and 21 days for SNF/MHs are allowed per calendar year. Additional days require precertification. The number of nonmedical reserve days is restricted to 21 days per year for ICF/MR residents. Providers will not be reimbursed for days a bed is held for a resident beyond the limits set forth above and will not reimburse for medical absences without precertification.

Please make sure to bill with the appropriate Revenue Codes within the 018x series. In addition, you would bill the appropriate accommodation code as well with a Value Code of 24 and billed as a cent(s). Example, if the accommodation code is 2, then you would bill the Value Code 24 with $0.02.
Long Term Services and Supports

Member Liability (Share of Cost)

Medi-Cal should be the payer of last resort. Anthem will ensure Medicare SNF benefits are exhausted prior to utilizing Medi-Cal benefits. Anthem will assist the facility in convening a discussion with the Member and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed.

The SNF is responsible for collecting the Member liability/Share of Cost amount each month and should represent the liability in box 39 on each claim. Please indicate the Share of Cost by billing the Value Code 23 with $0.00 or greater amount on the claim when submitting to Anthem. The payment remitted by Anthem will be reduced by the Member liability amount.

The SNF should also complete and send an MS-2126 to the case worker/care coordinator so the level of care is updated appropriately in the state’s system.

For circumstances in which the Member or responsible party fails to remit payment of the Member’s liability to the SNF, Anthem Care Coordinators will assist the facility in convening a discussion with the Member and/or responsible party and/or state staff, Adult Protective Service, law enforcement or others as needed. The facility administrator or manager should contact the Anthem Care Coordinators with details regarding the lack of payment of Member liability. Details should include:

- The date the last payment was made
- Discussions held with the Member/family to date
- Correspondence with the Member/family to date
- History of late and/or missed payments, if applicable, and
- Any knowledge of family dynamics, concerns regarding the responsible party, or other considerations

Upon approval of SNF eligibility, the state’s eligibility office will issue a notice of action that will identify the patient liability for the first month of eligibility and for the subsequent months. The Provider should then collect the patient liability consistent with the notice of action.

The following situations and responses are provided to assist you with addressing Member liability collection.

**Example 1**: The Member is approved for institutional SNF eligibility as of the 15th of the month.

- State issues notice of action for the month for the amount of $500 and for the following month forward of $1000 per month
- The facility per diem is $150: 150 x 15 = $2,250
- The facility collects the $500 patient liability, represents the amount on the claim form in box 39, and bills Anthem for $2250
- Anthem will reduce the $2250 by $500 and remit $1750

If a Member is discharged to home or expires mid-month, the Provider may retain the patient liability up to the total charges incurred for the month before discharge.
Example 2: The Member is approved for institutional nursing facility eligibility as of the first of the month and is discharged during the month.

- Patient liability is $1000
- Per diem is $150
- Member is discharged on day 7: 7 x $150 = $1050
- Provider retains all of the patient liability and represents the amount on the claim to the MCO.
- Member is discharged on day 3: 3x$150 = $450
- Provider refunds $550 to the Member/family or estate
- Provider submits a claim to MCO for 3 days representing the patient liability collected and MCO reduces the payment by the patient liability and issues a $0 claim payment

If a Member transfers facilities mid-month:

- Eligibility office is contacted regarding impending transfer and expected dates.
- Eligibility office issues a notice of action to the discharging facility for the patient liability it is to collect for the discharge month.
- Eligibility office issues a notice of action to the receiving facility as to the patient liability it is to collect in the first month and for subsequent months.

Long Term Services and Supports

Our Approach to Skilled Nursing Facility Member Liability/Share of Cost

Anthem recognizes the unique challenges faced by skilled nursing facility (SNF) Providers. Anthem has developed intensive training for nursing facilities to address a Member/family that is noncompliant in paying the Member liability; including facilitating a transfer if the issue cannot be resolved.

The paragraphs below outline our plan for working with the SNF and the Member/family to resolve such issues.

1. The SNF administrator or office manager contacts the Anthem Care Coordinator with details regarding the lack of payment of the Member liability including:
   - The date the last payment was made
   - Discussions held with the Member/family to date
   - Correspondence between the Member/family to date
   - History of late and/or missed payments, if applicable
   - Any knowledge of family dynamics, concerns regarding the responsible party, or other considerations

2. An Anthem Care Coordinator and the Nursing Home Social Worker, if applicable, discuss the issue with the Member, determine the barrier to payment, and elicit cooperation:
• The Anthem Care Coordinator guides the discussion using pre-determined talking points, including review of the obligation, potential impact to ongoing eligibility, and potential threat to continued residence at the current SNF.

• Anthem talking points will be provided to the State for review and approval as may be applicable.

• The Anthem Care Coordinator screens for any potential misappropriation of funds by family or representative payee.

3. The Anthem Care Coordinator will discuss the issue with the identified responsible party if the Member is unable to engage in a discussion regarding payment of the Member liability due to cognitive impairment or other disabilities.

4. The Anthem Care Coordinator or SNF Social Worker will take action if concerns related to misappropriation of funds are raised or suspected, and may:
   • Refer the Member to Adult Protective Services and/or law enforcement.
   • Submit request to the Social Security Administration to change the representative payee status to the person of the Member’s choosing or the SNF.
   • Engage additional family Members.
   • Engage the Guardianship Program to establish a conservator or guardian.

5. The Anthem Care Coordinator will request copies of the cancelled check or other bank document and/or request copy of receipt issued by the SNF for payment of liability if the Member or responsible party asserts that the required liability has been paid. The Care Coordinator will present evidence of payment to the SNF business office and request confirmation that the issue is resolved. The Anthem Care Coordinator will also engage the assigned Anthem LTSS Provider Relations Representative to work with the SNF to improve its processes.

6. Anthem will send correspondence that outlines the obligation to pay the Member liability, potential impact to ongoing eligibility, and potential threat to continued residence at the current SNF if the responsible party is unresponsive and/or living out of the area.

   The correspondence will be submitted to the State for review and approval as required.

   The correspondence will provide the responsible party with an opportunity to dispute the allegation and provide evidence of payment.

7. Anthem will take the following actions in conjunction with the SNF Social Worker if Member liability remains unsatisfied after the first rounds of discussion or correspondence:
   • Convene a formal meeting with the SNF leadership, Member and/or responsible party, Long-term Support Services Ombudsman, Adult Protective Services representative, other representative of the State as applicable, and other parties key to the discussion.
   • Review the patient liability obligation and potential consequences of continued nonpayment.
   • Attempt to resolve the payment gap with a mutually agreed-upon plan.
Chapter 5: LONG TERM SERVICES AND SUPPORTS (LTSS)

- Explain options if the Member or responsible party wishes to pursue transfer to another facility or discharge to the community

Anthem, together with the SNF, will engage in any of the following, as may be applicable if the Member liability continues to go unsatisfied:

- Update and escalate intervention by Adult Protective Services or law enforcement
- Refer to State Medicaid Fraud Control Unit or other eligibility of fraud management staff that the State may designate
- Escalate engagement to facilitate a change to representative payee, Power of Attorney, or Guardian
- Escalate appointment of a volunteer guardian or conservator
- Initiate discharge planning

**Long-Term Care Ethics and Quality Committee**

The Long-Term Care Ethics and Quality Committee addresses quality-of-care issues, ethical issues and standards of care. The committee reports to the Quality Management Committee.

The Anthem Quality Management program is a positive one. Our focus is on identification, improvement, education and support so Providers understand and comply with standards that impact the quality of care provided to our Members.

**Long Term Services and Supports Claims and Reimbursement Procedures**

**Precertification Requirements**

Precertification, sometimes referred to as Prior Authorization (PA), is required for all SNF and LTSS services for which Medicaid is the primary payer, including all levels of care, medical and nonmedical absences, hospice services rendered in a SNF, and Reserve Days (leaves of absence). The hospice Provider is responsible for obtaining precertification and is required to pay the SNF room and board charges.

Provider must submit precertification requests with all supporting documentation immediately upon identifying a SNF admission or at least 72 hours prior to the scheduled admission.

MSSPs that are receiving a PMPM for a member are not required to obtain an authorization. So we can ensure appropriate discharge planning, you must provide notice to Anthem via our precertification process when the following events occur:

- Admission to an acute care or behavioral health care facility
- Admission to hospice

For Members that enter the facility as “Medicaid Pending”, please request a precertification as soon as the state approves the Medicaid eligibility and the Member’s eligibility is reflected on the Anthem website.

The Anthem website and your Provider Manual list those services that require precertification and notification. Our Provider website also houses evidence-based criteria we use to complete precertification and concurrent reviews.
Anthem will follow the criteria established by DHCS authorizing short term or long term SNF stays.

The certification request can be submitted by:

- Fax the request to 1-866-333-4818
- Calling Care Management at 1-888-831-2246 (Select Option 2)
- For Members selecting Hospice services, Anthem will pay the hospice for the room and board charges, and the hospice will pay the SNF in accordance with CMS methodology and at the current applicable Medicaid rate

Providers can obtain the status of a precertification request by:

- Visiting our Provider website at www.anthem.com/ca

**Member Liability** (Share of Cost) should be reported on the CMS-1450/UB-04 claim form, Box 39. Your claim may be rejected if Box 39 is not populated. Please make sure to bill Value code 23 with $0.00 or greater amount. Even if multiple claims are submitted monthly and the Member Liability is met with the first claim, subsequent claims should indicate $0 liability with the Value Code 23.

**Retroactive adjustments**: Anthem understands the unique requirements of nursing facilities to accept residents as Medicaid pending. As soon as the facility receives notice from the state of the Medicaid approval, the facility should verify eligibility on the Anthem website and then request an authorization back to the date of eligibility as established by the state. Please note that it may take the state 24 to 48 hours to transmit an updated eligibility to the Anthem.

**Crossover Claims Procedures**: In most cases, when a resident has met the criteria for a Medicare qualified stay in a certified Medicare bed, the Medicare cost share will be relayed to Anthem via a crossover file provided to Anthem. We will then process and adjudicate the crossover claim. No further action should be necessary by the Provider. Should a crossover claim not be received by Anthem then a claim can be submitted by the provider with a copy of the EOP from the other carrier for processing.

**Corrected Claims Procedures**: A corrected claim Code XX7 or a replacement claim Code XX8 may be submitted within 60 calendar days of the original claim’s Explanation of Payment (EOP) date. When submitting a corrected claim, ensure that the applicable claim code is indicated on the claim form. Also ensure that corrected claims contain all applicable dates of service and/or Revenue Codes for processing.

**Accommodation Codes**: Accommodation codes are needed to ensure the appropriate reimbursement based on the Medi Cal rates established by the state for each facility. Please bill the appropriate accommodation code as well with a Value Code of 24 and billed as a cent(s). Example, if the accommodation code is 1, then you would bill the Value Code 24 with $0.01.
Accommodation codes are available on the Medi Cal Website at http://files.medi-cal.ca.gov/pubsdoco/manuals_menu.asp. Please access the manual for Long Term Care and refer to the section for Accommodation Codes.

**Long Term Services and Supports**

**Reimbursement to Multipurpose Senior Services Program Providers**

MSSP Providers must submit a monthly invoice/report to Anthem no later than the fifth day of each month for all Members for the reimbursement of the PMPM payment. The invoice/report shall be for each Anthem member enrolled in the MSSP as of the first day of the month for which the report is submitted. Anthem will pay the MSSP provider no later than thirty days after receipt of an undisputed claim. The report submitted must include the following:

- The name of the Anthem member receiving the MSSP services
- The member’s Client Index Number (CIN)
- The MSSP Provider’s ID number
- Other items as identified by both the health plan and the MSSP

Anthem pays MSSP Providers a fixed monthly amount for each Anthem member receiving MSSP Waiver Services. This amount is equal to one twelfth (1/12th) of the annual amount budgeted per MSSP Waiver slot allotment in the MSSP Waiver. This amount is provided by the state to Anthem.

MSSP Providers must accept Anthem’s payment as payment in full and final satisfaction of Anthem’s payment obligation for MSSP Waiver Services for each MSSP Waiver Participant enrolled in Anthem.

MSSP Providers may not submit separate claims to different plans for the same MSSP Waiver Participant within the same invoice period.

MSSP Providers must make timely payments to their subcontractors and/or vendors.

The MSSP would then submit an encounter claim to Anthem within 60 days from the date of services. The encounter claim would then be processed as zero payment to the MSSP.

Any questions can be directed to your LTSS provider relations representative. If you do not know your LTSS representative then you can email LTSSProviders@anthem.com.
CHAPTER 6: CREDENTIALING AND RE-CREDENTIALING

Credentialing and Re-credentialing

Credentialing Program Structure

The National Credentials Committee (NCC) is the authorized entity for the development and maintenance of National Credentialing Policy. Policies approved by NCC will govern credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation and appeals. Policies established by the National Credentials Committee will be presented to Anthem Blue Cross's Credentials Committee for input, review and adoption.

The NCC establishes a local credentialing and peer review body known as the Credentials Committee. The Credentials Committee (CC) is authorized by the NCC to evaluate and determine eligibility for practitioners and HDOs to participate in the credentialed networks and be listed in the Provider directories.

Credentialing and Re-credentialing

Credentialing Program Scope

Anthem Blue Cross credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing services covered under the Anthem Blue Cross Cal MediConnect Plan and doctors of dentistry providing Health Services covered under the Anthem Blue Cross Cal MediConnect Plan including oral maxillofacial surgeons.

Anthem Blue Cross 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 Blue Cross’s Network directory will be credentialed.

Anthem Blue Cross credentials the following Health Delivery Organizations (“HDOs”): hospitals; home health agencies; skilled nursing facilities; (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. Additional facilities and ancillary providers, including long term care services and support providers, are also subject to credentialing and re-credentialing.
Credentialing and Re-credentialing

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 Blue Cross Cal MediConnect Credentials Committee (“CC”).

The CC will meet at least once every forty-five (45) 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 Blue Cross Cal MediConnect Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem Blue Cross’s 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 Blue Cross** 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.

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**Credentialing and Re-credentialing**

**Nondiscrimination Policy**

**Anthem Blue Cross** will not discriminate against any applicant for participation in its Plan Programs or Networks 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 Blue Cross** 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 re-credentialing process. Determinations as to which practitioners/ HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in **Anthem Blue Cross** Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

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**Credentialing and Re-credentialing**

**Initial Credentialing**

Each practitioner or Health Delivery Organization (HDO) must complete a standard application form when applying for initial participation in the **Anthem Blue Cross Cal MediConnect** Network. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem Blue Cross For practitioners, the Council for Affordable Quality Healthcare (“CAQH”), a Universal Credentialing Datasource 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 web site at [www.CAQH.org](http://www.CAQH.org).

**Anthem Blue Cross** 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 and 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 Blue Cross** 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**

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating</td>
</tr>
<tr>
<td>Covered Individuals.</td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a</td>
</tr>
<tr>
<td>Network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA, CDS and state controlled substance certificates</td>
</tr>
<tr>
<td>• The DEA/CDS must be valid in the state(s) in which practitioner will be treating</td>
</tr>
<tr>
<td>Covered Individuals. Practitioners who see members in more than one state must</td>
</tr>
<tr>
<td>have a DEA/CDS for each state.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or Federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
<tr>
<td>National Practitioner Data Bank report</td>
</tr>
</tbody>
</table>

B. **Health Delivery Organizations (HDOs)**

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accreditation, if applicable</td>
</tr>
<tr>
<td>License to practice, if applicable</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
<tr>
<td>Medicare certification, if applicable</td>
</tr>
<tr>
<td>Department of Health Survey Results or recognized accrediting organization certification</td>
</tr>
<tr>
<td>License sanctions or limitations, if applicable</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEHBP sanctions</td>
</tr>
</tbody>
</table>

**Credentialing and Re-credentialing**

**Re-credentialing**

The re-credentialing 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 Blue Cross**’s credentialing standards.
During the re-credentialing process, Anthem Blue Cross 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 Blue Cross’s Credentialing Program are required to be re-credited every three (3) years unless otherwise required by contract or state regulations.

Creditneing and Re-credentialing

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem Blue Cross for review. If the candidate meets Anthem Blue Cross’s screening criteria, the credentialing process will commence. To assess whether participating Anthem Blue Cross Cal MediConnect Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and re-credentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Blue Cross’s 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 Blue Cross may evaluate the most recent site survey by Medicare or the appropriate state oversight agency for that HDO.

Re-credentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in the Anthem Blue Cross Cal MediConnect Network must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem Blue Cross 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.

Credentialing and Re-credentialing

Ongoing Sanction Monitoring

To support certain credentialing standards between the re-credentialing cycles, Anthem Blue Cross 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")
Chapter 6: CREDENTIALING AND RE-CREDENTIALING

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 Blue Cross**’s 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 Blue Cross**’s CC, review by the **Anthem Blue Cross** Medical Director, referral to the CC, or termination. **Anthem Blue Cross**’s credentialing departments will report Providers to the appropriate authorities as required by law.

**Credentialing and Re-credentialing Appeals Process**

**Anthem Blue Cross** has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in the **Anthem Blue Cross Cal MediConnect Plan** Network. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and **Anthem Blue Cross** may wish to terminate practitioners or HDOs. **Anthem Blue Cross** also seeks to treat practitioners and HDOs and applying Providers fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in **Anthem Blue Cross**’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 Blue Cross** 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 Blue Cross** to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in the **Anthem Blue Cross Cal MediConnect Plan** Network 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 Blue Cross**’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.
Credentialing and Re-credentialing

Reporting Requirements

When Anthem Blue Cross takes a professional review action with respect to a practitioner’s or HDO’s participation in the Anthem Blue Cross Cal MediConnect Network, Anthem Blue Cross may have an obligation to report such to the NPDB and/or Healthcare Integrity and Protection Data Bank (“HIPDB”). Once Anthem Blue Cross 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.

Credentialing and Re-credentialing

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

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 & 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 Orthopedics and Primary Podiatric Medicine (“ABPOPPM”) 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 Blue Cross 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 Blue Cross 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 Blue Cross review and approval. Reports submitted by delegate to Anthem Blue Cross must contain sufficient documentation to support the above alternatives, as determined by Anthem Blue Cross.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a 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/Participating Provider to provide inpatient care.
Credentialing and Re-credentialing
Criteria for Selecting Practitioners – 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 Blue Cross upon receipt of the required DEA.
   d. Anthem Blue Cross will verify the appropriate DEA/CDS via standard sources.
      i. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) 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:
         • It can be verified that this application is pending and,
         • The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,
• The applicant agrees to notify Anthem Blue Cross upon receipt of the required DEA,
• **Anthem Blue Cross** 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
• 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 an Anthem Blue Cross 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 & 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. an 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 re-credentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

Credentialing and Re-credentialing
Currently Participating Applicants (Re-credentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
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 re-credentialing 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/Participating Provider of similar specialty at a Network hospital 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. Re-credentialed at least every three (3) years to assess the practitioner’s continued compliance with Anthem Blue Cross standards.

*It is expected that these findings will be discovered for currently credentialed Providers and Facilities through ongoing sanction monitoring. Providers and Facilities 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 re-credentialing.
Credentialing and Re-credentialing
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 (“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 Provider 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 or 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)
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

**Credentialing and Re-credentialing**

**Eligibility Criteria – Health Delivery Organizations (HDOs)**

All HDOs must be accredited by an appropriate, recognized accrediting body; in the absence of such accreditation, **Anthem Blue Cross** 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 Blue Cross**’s standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are re-credentialed at least every three (3) years to assess the HDO’s continued compliance with **Anthem Blue Cross**’s standards.

**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 Blue Cross**.
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 Blue Cross**’s quality and certification criteria standards have been met.

**Additional Participation Criteria for HDO by Provider Type**

**MEDICAL FACILITIES**

<table>
<thead>
<tr>
<th>Facility Type (MEDICAL CARE)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>TJC, HFAP, NIAHO</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>TJC, HFAP, AAPSF, AAAHC, AAAASF, IMQ</td>
</tr>
<tr>
<td>Free Standing Cardiac Catheterization Facilities</td>
<td>TJC, HFAP (may be covered under parent institution)</td>
</tr>
<tr>
<td>Lithotripsy Centers (Kidney stones)</td>
<td>TJC</td>
</tr>
<tr>
<td>Home Health Care Agencies</td>
<td>TJC, CHAP, ACHC</td>
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<tr>
<td>Skilled Nursing Facilities</td>
<td>TJC, CARF</td>
</tr>
<tr>
<td>Nursing Homes</td>
<td>TJC</td>
</tr>
</tbody>
</table>
### BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Facility Type (BEHAVIORAL HEALTH CARE)</th>
<th>Accreditation Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO,</td>
</tr>
<tr>
<td>Residential Care—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO CARF</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Psychiatric Disorders</td>
<td>TJC, HFAP, NIAHO CARF for programs associated with an acute care facility or Residential Treatment Facilities.</td>
</tr>
</tbody>
</table>
| Intensive Structured Outpatient Program—Psychiatric Disorders | TJC, HFAP NIAHO 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  |
| 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 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. |
CHAPTER 7: PERFORMANCE AND TERMINATION

Performance and Termination

Performance Standards and Compliance

All Providers must meet specific performance standards and compliance obligations. When evaluating a Provider’s performance and compliance, Anthem Blue Cross reviews a number of clinical and administrative practice dimensions, including:

- Quality of care — measured by clinical data related to the appropriateness of care and outcomes
- Efficiency of care — measured by clinical and financial data related to health care costs
- Member satisfaction — measured by the Members’ reports regarding accessibility, quality of health care, Member/Provider relations and the comfort of the office setting
- Administrative requirements — measured by the Provider’s methods and systems for keeping records and transmitting information
- Participation in clinical standards — measured by the Provider’s involvement with panels used to monitor quality of care standards

Providers must:

- Comply with all applicable laws and licensing requirements
- Furnish covered services in a manner consistent with professionally recognized standards of medical and surgical practice generally accepted in the professional community at the time of treatment
- Comply with Anthem Blue Cross standards, including:
  - Guidelines established by the Centers for Disease Control and Prevention (or any successor entity)
  - Federal, state and local laws regarding professional conduct
    - Comply with Anthem Blue Cross policies and procedures regarding the following:
      - Participating on committees and clinical task forces to improve the quality and cost of care
      - Pre-notification and/or precertification requirements and time frames
      - Provider credentialing requirements
      - Referral policies
      - Case Management Program referrals
      - Appropriately releasing inpatient and outpatient utilization and outcomes information
      - Providing accessibility of Member medical record information to fulfill Anthem Blue Cross business and clinical needs as well as Member needs
      - Cooperating with efforts to assure appropriate levels of care
      - Maintaining a collegial and professional relationship with Anthem
Blue Cross personnel and fellow Providers

- Providing equal access and treatment to all Anthem Blue Cross Cal MediConnect Plan Members

The following types of noncompliance issues are key areas of concern:

- Member complaints and grievances filed against the Provider
- Underutilization, overutilization or inappropriate referrals
- Inappropriate billing practices, such as balance billing of Anthem Blue Cross Cal MediConnect Plan Members for amounts that are not their responsibility
- Unnecessary out-of-network referrals and utilization (which require precertification)
- Failure to provide advance notice of admissions or precertification of discharges from inpatient facilities, comprehensive outpatient rehabilitation facilities or home health care services
- Non-supportive actions and/or attitude

Provider noncompliance is tracked on a calendar year basis. Corrective actions are taken as appropriate.

Performance and Termination

Physician – Patient Communications

Providers acting within the lawful scope of practice are encouraged to advise Anthem Blue Cross Cal MediConnect Plan Members of the following:

- Health status, medical care or treatment options (including any alternative treatments that may be self-administered), including the provision of sufficient information to provide an opportunity for the patient to decide among all relevant treatment options
- Risks, benefits and consequences of treatment or non-treatment
- Opportunity for the individual to refuse treatment and to express preferences about future treatment decisions

Physician and patient communications are a necessary component of standard medical practice. Although coverage under this program is determined by Anthem Blue Cross, the Provider along with the Member remains responsible for all treatment decisions related to Anthem Blue Cross Cal MediConnect Member.

Performance and Termination

Provider Participation Decisions: Appeals Process

Upon a denial, suspension, termination or nonrenewal of a Provider’s participation in the Anthem Blue Cross Cal MediConnect Provider network, Anthem Blue Cross acts as follows:

- The affected physician is given a written notice of the reasons for the action, including if
relevant the standards and profiling data used to evaluate the physician and the
numbers and mix of physicians needed by Anthem Blue Cross

- The physician is allowed to appeal the action to a hearing panel
- The physician is provided written notice of the right to a hearing and the process and
timing for requesting a hearing
- **Anthem Blue Cross** ensures the majority of the hearing panel members are peers of the
affected physician
- **Anthem Blue Cross** notifies the National Practitioner Data Bank, the appropriate state
licensing agency and any other applicable licensing or disciplinary body to the extent
required by law, if a suspension or termination is the result of quality of care
deficiencies
- Subcontracted physician groups must ensure these procedures apply equally to
physicians within those subcontracted groups.
- **Anthem Blue Cross** notifies CMS and DHCS within seven calendar days, via the CMT,
when it terminates, suspends, or declines a Provider from its network because of fraud,
integrity, or quality

Anthem Blue Cross decisions subject to an appeal include decisions regarding reduction,
suspension or termination of a Provider’s participation resulting from quality deficiencies.
Anthem Blue Cross notifies the National Practitioner Data Bank, the appropriate state
licensing agency and any other applicable licensing or disciplinary body to the extent required by law.
Written communication to the Provider details the deficiencies and informs him or her of the
right to appeal.

Performance and Termination

**Notification to Members of Provider Termination**

Anthem Blue Cross makes a good faith effort to provide notice to each Member who received
his or her care from the Provider or was seen on a regular basis by the Provider within 15
calendar days of receipt or issuance of the termination notice. Anthem Blue Cross may provide
Member notification in less than 15 days’ notice as a result of a Provider’s death or exclusion
from the federal health programs.

When a termination involves a PCP or any medical, behavioral health or long-term services and
supports provider all Members who are patients of that Provider are notified of the
termination.

For Members who are receiving treatment for a chronic or ongoing medical condition or LTSS,
Anthem Blue Cross will ensure there is no disruption in services provided.
CHAPTER 8: QUALITY MANAGEMENT

Quality Management
Overview

Anthem Blue Cross maintains a comprehensive Quality Management (QM) program to objectively and systematically monitor and evaluate care and service provided to Members. The scope and content of the program reflects the demographic, epidemiologic, medical and behavioral health needs of the population served. Key components of the program include but are not limited to:

- Quality of Member care and service
- Accessibility and availability of services
- Member safety and prevention
- Continuity and coordination of care
- Appropriateness of service utilization
- Cultural competency
- Member outcomes
- Member and Provider satisfaction
- Regulatory and accreditation standards

Members and Providers have opportunities to participate in quality management and make recommendations for areas of improvement through complaints, grievances, appeals, satisfaction or other surveys, committee participation where applicable, quality initiatives/projects, and calls to the health plans. QM program goals and outcomes are available to Providers and Members upon request.

Quality activities are planned across the continuum of care and service with ongoing proactive evaluation and refinement of the program.

The Anthem Blue Cross QM program tracks and trends quality of care issues and service concerns identified for all care settings. QM staff review Member complaints/grievances, reported adverse events and other information to evaluate the quality of service and care provided to our Members.

Quality Management
Centers for Medicare & Medicaid Services

The Centers for Medicare & Medicaid Services (CMS) evaluates all Medicare Advantage (MA) and Prescription Drug (MA-PD) plans through the use of Healthcare Effectiveness Data and Information Set (HEDIS) metrics. Many of the measures included in the CMS evaluation are measures of preventive care management. Some of these are listed below and are subject to change:

- Staying healthy — screening, tests and vaccines:
Breast cancer screening
- Colorectal cancer screening
- Cholesterol screening for cardiovascular and diabetes care
- Annual flu vaccine
- Improving and maintaining physical and mental health
- Monitoring physical activity
- Adult body mass index assessment

Managing chronic conditions:
- Care for the older adult: medication review, functional status assessment and pain screening
- Managing osteoporosis in women who had a fracture
- Obtaining diabetes care for eye exams, kidney disease monitoring, and blood sugar and cholesterol control
- Controlling blood pressure
- Managing rheumatoid arthritis
- Improving bladder control
- Reducing the risk of falling
- Plan all-cause readmissions
- Medication adherence and management (oral diabetics, hypertension and cholesterol medications)

With the growing focus on quality health care and plan Member satisfaction, CMS and the State assess plan performance. One of the assessment tools used is the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Beneficiaries who receive health care services through the California Cal MediConnect receive CAHPS surveys through the mail.

The survey asks the California Cal MediConnect beneficiary to assess his or her health and the care received from his or her primary care Providers and specialists over the past six months. The survey includes questions regarding Providers’ communication skills and the Member’s perception about his or her access to needed health care services. The survey questions ask the Member to report his or her opinion about access to care and the health plan’s customer service. It also asks the Member to rate the communication received from his or her Providers.

A second assessment tool used by CMS is the Health Outcomes Survey (HOS) to evaluate all managed care organizations ability to maintain or improve the physical and mental health functioning of its Medicare beneficiaries over a two-year period of time. The survey is used as a way of measuring how the care provided by the health plan is affecting the functional status of their enrollees. CMS includes the HOS in their performance assessment program.

This survey is sent out in two cohorts. The first cohort records baseline data. If a member answers the first survey they are sent a second survey in two years, these results become part
of the effectiveness of care ratings for the health plan.

**Anthem Blue Cross** encourages participating Providers to help improve Member satisfaction by:

- Ensuring Members receive appointments within acceptable time frames as outlined in the Access and Availability Standards Table in this manual
- Educating Members and talking to them during each visit about their preventive health care needs
- Ensuring Providers answer any questions Members have regarding newly prescribed medications
- Ensuring Members know to bring all medications and medical histories to their specialists and knows the purpose of a specialist referral
- Allowing time during the appointment to validate Members’ understanding of their health conditions and the services required for maintaining a healthy lifestyle
- Referring Members to the Member Services department at Cal MediConnect Customer Care and speaking to a case manager

**Quality Management Committee Structure**

**Anthem Blue Cross** maintains a comprehensive quality management committee structure as noted below with program oversight by the board of directors.

**Quality Management Quality Improvement Committee**

The purpose of the Quality Improvement Committee is to provide leadership and oversight of the health plan quality management programs, improve safety and quality of care and services, improve customer service, and improve operating efficiencies.

Responsibilities include:

- Review and approval of the program descriptions
- Work plans and annual evaluations for quality management, utilization management, health promotion, credentialing, case management and pharmacy
- Review and approval reporting of complaints, appeals and Service Level Agreements (SLAs)
- Review of regular standardized reports (at least semi-annually) delineating progress towards goals of the program, actions taken, improvements made, focused study results and follow-up actions on identified opportunities
- Evaluation of resource adequacy to ensure effective implementation of the programs and ongoing effectiveness
• Recommending policy decisions
• Instituting needed actions and ensure completion
• Ensuring practitioner participation

Quality Management Committee

The purpose of the health plan Quality Management Committee (QMC) is to maintain quality as a cornerstone of Anthem Blue Cross culture and to be an instrument of change through demonstrable improvement in care and service.

The QMC’s responsibilities are to:

• Review regular standardized reports, at least semi-annually, delineating progress towards clinical goals, actions taken and improvements
• Establish processes and structure that ensure CMS compliance
• Analyze, review and make recommendations regarding the planning, implementation, measurement, and outcomes of the clinical/service quality improvement projects (QIP)
• Coordinate communication of quality management activities throughout the Health Plan
• Review CMS Stars, HEDIS®, HOS® and CAHPS® data and action plans for improvement
• Review, monitor and evaluate program compliance against the Health Plan, State, Federal and CMS standards
• Review of LTSS credentialing issues, as applicable
• Review and approve the annual Quality Management Program Description and Work Plan and the QM Program Evaluation
• Evaluate the overall effectiveness of the SNP Model of Care including regular reports, performance outcomes and satisfaction, barrier analysis, effectiveness of interventions and adequacy of resources
• Oversee the compliance of delegated services and delegation oversight activities
• Assure inter-departmental collaboration, coordination and communication of quality improvement activities
• Measure compliance to medical and behavioral health practice guidelines
• Monitor continuity of care between medical and behavioral health services
• Monitor accessibility and availability
• Publicly make information available to enrollees and practitioners about the network hospital’s action to improve patient safety
• Make information available about the QM program to enrollees and practitioners
CHAPTER 9: HEALTH CARE MANAGEMENT SERVICES

Health Care Management Services

Overview

Anthem Blue Cross continuously seeks to improve the quality of care provided to its Members. We encourage and expect our Providers to participate in health promotion programs. Providers are encouraged to collaborate with Anthem Blue Cross in efforts to promote healthy lifestyles through Member education and information sharing.

Providers must fully comply with:

- Health care management services policies and procedures
- Quality improvement and other performance improvement programs
- All regulatory requirements

The health care delivery system is a gatekeeper model that supports the role and relationship of the Primary Care Provider (PCP). The model includes direct contracts with PCPs, hospitals, specialty physicians and other Providers, as required, to deliver Medicare and Medicaid benefits, additional benefits and the Anthem Blue Cross Cal MediConnect Plan for Members with complex medical needs. All contracted Providers are available to Anthem Blue Cross Cal MediConnect Members by PCP or self-referral for the services identified below.

The gatekeeper model requires all Members to select a PCP upon joining the plan. Members who do not choose a PCP are assigned one. Anthem Blue Cross works with the Member, the physician and the Member’s representative, as appropriate, to ensure the PCP is suitable to meet the Member’s individual needs. Members must have access to their PCP or a covering physician 24 hours a day, 7 days a week.

Health Care Management Services

Self-Referral Guidelines

Anthem Blue Cross Cal MediConnect Plan Members may self-refer for the following services:

- Screening mammograms
- Behavioral health
- Influenza and pneumococcal vaccinations
- Routine physical examinations, prostate screening and preventive women’s health services (e.g., Pap smears)

Except for emergent or out-of-area urgent care and dialysis services, in general, Members must obtain services within the Anthem Blue Cross Cal MediConnect Plan network or obtain a precertification for covered services outside the network.
Health Care Management Services

Referral Guidelines

PCPs may only refer Members to Anthem Blue Cross Cal MediConnect Plan contracted network specialists to ensure the specialist receives appropriate clinical background data and is aware of the Member’s ongoing primary care relationship. If a Member wants to receive care from a different specialist or the required specialty is not available within the contracted network, the PCP should contact Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. PCPs must obtain precertification from Anthem Blue Cross before referring Members to non-plan Providers.

Health Care Management Services

Authorization/Precertification

Certain services/procedures require precertification from Anthem Blue Cross for participating and nonparticipating PCPs and specialists and other providers. Please refer to the list below or the Precertification Lookup tool online, or call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786 for more information. You can also access information concerning precertification requirements on our website at www.anthem.com/CA

The following are examples of services requiring precertification before providing the following non-emergent or urgent care services:

- Inpatient mental health services
- Behavioral health partial hospitalization
- Skilled Nursing Facility (SNF)
- Home health care
- Diagnostic tests, including but not limited to MRI, MRA, PET scans, etc.
- Hospital or ambulatory care center-based outpatient surgeries for certain procedures
- Elective inpatient admissions
- Transplant evaluation and services
- Any non-emergency service from or referral to a non-contracted Provider
- Durable Medical Equipment (DME)
- Outpatient IV infusion or injectable medications
- Prosthetics
- Certain reconstructive procedures
- Occupational, speech and physical therapy services
- Long Term Services and Supports
Health Care Management Services
Medically Necessary Services and Medical Criteria

Medically necessary services are medical services or hospital services determined by Anthem Blue Cross to be:

- Rendered for the diagnosis or treatment of an injury or illness
- Appropriate for the symptoms, consistent with diagnosis and otherwise in accordance with sufficient scientific evidence and professionally recognized standards
- Not furnished primarily for the convenience of the Member, the attending Provider or other Provider of service

Medical necessity decisions are objective, based on medical evidence and applied according to the individual needs of the Member and an assessment of the local delivery system. Anthem Blue Cross makes utilization management criteria available to practitioners upon request. If a medical necessity decision results in a denial, practitioners are welcome to discuss the denial decision with the Medical Director. All denial decisions are made by appropriately licensed and qualified physicians. Practitioners can obtain utilization management criteria or speak to a Medical Director by calling Provider Services at the Cal MediConnect Customer Care at 1-855-817-5786.

Anthem Blue Cross makes determinations of medical necessity based on CMS National Coverage Determinations (NCD), Local Coverage Determinations (LCD), other coverage guidelines and instructions issued by CMS and the State and legislative changes in benefits. In coverage situations where there is no NCD, LCD or guidance on coverage in original Medicare or Medicaid manuals, Anthem Blue Cross will make a determination on medical necessity based on authoritative evidence as documented by Milliman, CMS and State guidelines and Anthem Blue Cross policies as a guideline.

In some instances, Anthem Blue Cross may develop its own coverage policies. In these instances, the following standards apply to the development of the criteria:

- Criteria are developed with involvement from appropriate Providers with current knowledge relevant to the content of treatment guidelines under development
- Criteria are objective, based on medical evidence, review of market practice, national standards and best practices
- Criteria are evaluated at least annually by appropriate, actively practicing physicians and other Providers with current knowledge relevant to the criteria of treatment guidelines under review and updated, as necessary
- The criteria must reflect the names and qualifications of those involved in the development, the process used in the development and when and how often the criteria will be evaluated and updated
- The criteria cannot be more restrictive or limiting than CMS or State guidelines or requirements
These guidelines are communicated to Providers through Anthem Blue Cross blast fax notices, letters and newsletters. Communications are posted to the Anthem Blue Cross self-service website at www.anthem.com/CA
CHAPTER 10: MEDICAL MANAGEMENT

Medical Management
Requirements Overview

Anthem Blue Cross Cal MediConnect Plan Providers must maintain permanent medical records that are:

- Current, detailed and organized; permit effective, confidential patient care; and allow quality reviews
- In conformity with good professional medical practice and appropriate health management
- Located at the primary care site for every Anthem Blue Cross Cal MediConnect Plan Member
- Kept in accordance with Anthem Blue Cross and state standards as described in this manual
- Retained for 10 years from the final date of the contract or from the date of completion of any audit
- Accessible upon request to Anthem Blue Cross, any state agency and the federal government

Anthem Blue Cross will:

- Systematically review medical records to ensure compliance with standards. The health plan’s MAC oversees and directs Anthem Blue Cross in formalizing, adopting and monitoring guidelines
- Institute actions for improvement when standards are not met
- Maintain a record-keeping system that is designed to collect all pertinent medical management information for each Member
- Make information readily available to appropriate health professionals and appropriate state agencies
- Use nationally recognized standards of care and work with Providers to develop clinical policies and guidelines of care for Members

Medical Management Support
Case Management

The Anthem Blue Cross Case Management Solutions Program is a Member-centric, integrated continuum of care model that strives to address the totality of each Member’s physical, behavioral, cognitive, functional and social needs.
The scope of the Case Management Solutions Program includes but is not limited to:

- Member identification using a prospective approach that is designed to focus case management resources for Members expected to be at the highest risk for poor health outcomes
- Initial and ongoing assessment
- Problem-based, comprehensive care planning to include measurable goals and interventions tailored to the complexity level of the Member as determined by initial and ongoing assessments
- Coordination of care with PCPs and specialty Providers
- Member education
- Member empowerment using motivational interviewing techniques
- Facilitation of effective Member and Provider communications
- Program monitoring and evaluation using quantitative and qualitative analysis of data
- Satisfaction and quality of life measurement

Using a prospective systematic approach, Members with a risk of poor health outcomes are identified and targeted for case management services that are tailored to their condition and risks. This continuous case finding system evaluates Members of a given population based on disease factors and claims history with the goal of improving quality of life through proper utilization of necessary services and a reduction in the use of unnecessary services.

Case management Member candidate lists are updated monthly and prioritized to identify Members with the highest expected needs for service. Case management resources are focused on meeting listed Members’ needs by using a combination of standardized and individualized approaches.

A core feature of the Anthem Blue Cross Case Management Solutions Program is the emphasis on an integrated approach to meeting the needs of Members. The program considers the whole person, including the full range of each Member’s physical, behavioral, cognitive, functional and social needs. The role of the case manager is to engage Members of identified risk populations and to follow them across health care settings, to collaborate with other health care team Members to determine goals and to provide access to resources and monitor utilization of resources. The case manager works with the Member to identify specific needs and interfaces with the Member’s Providers with the goal of facilitating access to quality, necessary, cost-effective care.

Using information gathered through the assessment process, including a review of the relevant evidence-based clinical guidelines, the case manager develops a goal-based care plan that includes identified interventions for each diagnosis, short- and long-term goals, interventions designed to assist the Member in achieving these goals and identification of barriers to meeting goals or complying with the care plan.

Assessment information, including feedback from Members, family/caregivers and in some cases Providers, provides the basis for identification of problems. Areas identified during the
assessment that may warrant intervention include but are not limited to:

- Conditions that compromise Member safety
- History of high service utilization
- Use of inappropriate services
- Current treatment plan that has been ineffective
- Permanent or temporary loss of function
- High-cost illnesses or injuries
- Comorbid conditions
- Medical/psychological/functional complications
- Health education deficits
- Poor or inconsistent treatment/medication adherence
- Inadequate social support
- Lack of financial resources to meet health or other basic needs
- Identification of barriers or potential barriers to meeting goals or complying with the care plan

Preparation of the care plan includes an evaluation of the Member’s optimal care path, as well as the Member’s wishes, values and degree of motivation to take responsibility for meeting each of the care plan goals. Wherever possible, the case manager encourages the Member to suggest his or her own goals and interventions, as this may increase their investment in their successful completion.

Our case managers work closely with the Member and Providers to develop and implement the plan of care. As a Provider, you may receive a call from the case manager or a copy of the Member’s care plan may be sent to you.

**Medical Management Support**

**Model of Care**

Anthem Blue Cross has developed an evidenced based model of care that offers coordinated care delivered by a network of Providers with expertise to meet the needs of the specialized population. The effectiveness of the model of care is measured annually as part of our Quality Management Program. We have designed a care system to meet the intentions of the California Cal MediConnect program, a coordinated, integrated person-centered system of care that assures high quality and an excellent Member experience.

The model of care is a comprehensive care management and care coordination program that incorporates our experience and the goals of the California Cal MediConnect Program.
The goals of California Cal MediConnect program are to:

- Improve the quality of care for Members
- Maximize the ability of Members to remain safely in their homes and communities with appropriate services and supports, in lieu of institutional care
- Coordinate Medicare and Medicaid benefits across health care settings and improve continuity of care across acute care, long-term care, behavioral health, and home and community-based services settings by using a person-centered approach
- Promote a system that is both sustainable and person- and family-centered, and enables Members to attain or maintain personal health goals by providing timely access to appropriate, coordinated health care services and community resources, including home- and community-based services and mental health and substance use disorder services
- Increase the availability and access to LTSS including HCBS
- Improve transitions of care across health care settings, Providers and HCBS.
- Maximize the ability of dual eligible Members to remain in their homes and community based settings with appropriate services and supports in lieu of institutional care
- Preserve and enhance the ability for Members to self-direct their care and receive high quality care
- Optimize the use of Medicare, Medicaid and other State/County resources

Each Member has an interdisciplinary care team (ICT) assigned to assist with developing care plans, collaborating with other team members and providing recommendations for the management of the Member’s care. The representative of the team and the mode of communication are determined by the needs of the Member. Typically the team can be made up of Member and/or his or her designee, designated care manager, primary care physician, behavioral health professional, the Member’s home care aide or LTSS Provider and other Providers either as requested by the Member or his/her designee or as recommended by the care manager or primary care physician and approved by the Member and/or his/her designee.

The Member is an important part of the team and is involved in the planning process. The Member’s participation is voluntary and they can choose to decline at any time. The case manager is the coordinator of the team and reaches out to Providers and other team members to coordinate the needs of the Member. Important information about the Member including the assessment and care plan details are available to you through the secured provider portal. Health care practitioners and Providers of care in the home or community are also very important members of the team and help to establish and execute the care plan.

All case management and ICT are person-centered and built on the Member’s specific preferences and needs, ensuring transparency, individualism, accessibility, respect, linguistic and cultural competency and dignity.
The figure above demonstrates the person-centricity of the model. Depending on Member conditions, needs and desires, a team comprised of experts in Physical Health, Behavioral Health, LTSS, Social Work works with the Member, their representative (if desired) and the PCP and Specialists as required. Communication among all the constituents is critical and is supported by Anthem Blue Cross systems.

**Medical Management**

**Member Medical Records Standards**

We require medical records to be current, detailed and organized for effective, confidential patient care and quarterly review. Your medical records must conform to good professional medical practice and be permanently maintained at the primary care site.

Members are entitled to one copy of their medical record each year provided at no cost. Members or their representatives should have access to these records.

**Our medical records standards include:**

- Patient identification information — patient name or ID number must be shown on each page or electronic file
- Personal/biographical data — age, sex, address, employer, home and work telephone numbers, and marital status
• Date and corroboration — dated and identified by the author
• Legibility — if someone other than the author judges it illegible, a second reviewer must evaluate it
• Allergies — must note prominently:
  – Medication allergies
  – Adverse reactions
  – No Known Allergies (NKA)
• Past medical history — for patients seen three or more times. Include serious accidents, operations, illnesses and prenatal care of mother and birth for children
• Immunizations — a complete immunization record for pediatric Members age 20 and younger with vaccines and dates of administration
• Diagnostic information
• Significant illnesses and chronic and recurrent medical conditions are indicated in the problem list on all Member medical records
• Report contributory and/or chronic conditions if they are monitored, evaluated, addressed or treated at the visit and impact of the care.
• All diagnoses reported on the claim should be fully documented in the medical record, and each diagnosis noted in the medical record should be reported in the claim corresponding to that encounter.
• Medical information, including medication(s) and instruction to patient
• Identification of current problems
  – Serious illnesses
  – Medical and behavioral conditions
  – Health maintenance concerns
• Instructions including evidence the patient was provided basic teaching and instruction for physical or behavioral health condition
• Smoking/alcohol/substance abuse — notation required for patients age 12 and older and seen three or more times
• Consultations, referrals and specialist reports — consultation, lab and X-ray reports must have the ordering physician’s initials or other documentation signifying review; any consultation or abnormal lab and imaging study results must have an explicit notation
• Emergencies — all emergency care and hospital discharge summaries for all admissions must be noted
• Hospital discharge summaries — must be included for all admissions while enrolled and prior admissions when appropriate
• Advance Directives — must document whether the patient has executed an advance directive such as a living will or durable power of attorney
• All documentation required by the State for existing programs
Medical Management  
Documentation Standards for an Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the Member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the Member’s age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a Member by a Provider or facility for the same specific medical problem or condition.

Documentation for all episodes of care must meet the following criteria:

- Documentation is legible
- Contains information that identifies the Member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)
Medical Management
Other Documentation Not Directly Related to the Member

Records should contain information relevant to support clinical practice and used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

Anthem Blue Cross may request that you submit additional documentation, including medical records or other documentation not directly related to the Member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

Anthem Blue Cross is not liable for interest or penalties when payment is denied or recouped because the Provider fails to submit required or requested documentation.

Medical Management
Patient Visit Data Records Standards

You must provide:

- A history and physical exam with both subjective and objective data for presenting complaints
- Behavioral health treatment, including at-risk factors:
  - Danger to self/others
  - Ability to care for self
  - Affect
  - Perpetual disorders
  - Cognitive functioning
  - Significant social health
- Admission or initial assessment must include:
  - Current support systems
  - Lack of support systems
- Behavioral health treatment — documented assessment at each visit for client status and symptoms, indicating:
  - Decreased
  - Increased
Chapter 10: MEDICAL MANAGEMENT

Anthem Blue Cross

Anthem Blue Cross Cal MediConnect Plan

Unchanged

A plan of treatment, including:
- Activities
- Therapies
- Goals to be carried out
- Diagnostic tests
- Evidence of family involvement in therapy sessions and/or treatment

- Follow-up care encounter forms or notes indicating follow-up care, call or visit in weeks, months or PRN
- Referrals and results of all other aspects of patient care and ancillary services

We systematically review medical records to ensure compliance and institute actions for improvement when our standards are not met.

We maintain a professional recordkeeping system for services to our Members. We make all medical management information available to health professionals and state agencies and retain these records for seven years from the date of service.

Medical Management

Medical Record Review

Federal regulations require managed care organizations and their agents review medical records to avoid over- or under-payment and verify documentation to support of diagnostic conditions. Additionally, health plan leadership for quality management and the Quality Management Committee conduct medical record audits periodically and use the results in the Provider re-credentialing process.

Medical Management

Risk Adjustment Data Validation

Participation in risk adjustment data validation is required of all Providers, and it is important that you are aware that medical records may be requested from your office. Data validation through a review of medical record documentation ensures the accuracy of risk-adjusted payments. These medical record reviews verify the accuracy of claim and encounter data and identify additional conditions not captured through this mechanism.

Anthem Blue Cross may contract with a third-party vendor to acquire medical records or conduct onsite reviews. Under CFR 164.502 (Health Insurance Privacy and Accountability Act [HIPAA] implementation), Providers are permitted to disclose requested data for the purpose of health care operations after they have obtained the “general consent” of the Member. A general consent form should be an integral part of your medical record file.

More information related to risk adjustment can be found at www.cms.gov.
Medical Management
Clinical Practice Guidelines

Using nationally recognized standards of care, Anthem Blue Cross works with Providers to develop clinical policies and guidelines for the care of its Membership. The Medical Advisory Committee (MAC) oversees and directs Anthem Blue Cross in formulating, adopting and monitoring guidelines.

Anthem Blue Cross selects at least four evidence-based Clinical Practice Guidelines (CPGs) relevant to the Member population. The guidelines are reviewed and revised by the Anthem Blue Cross Quality Improvement Council at least every two years or whenever the guidelines change.

The Anthem Blue Cross CPGs are located online at www.anthem.com/CA. To access the CPGs, log in to the secure site with your user name and password and select the Clinical Practice Guidelines link from the Clinical Policy and Guidelines section on the top navigation menu. A copy of the guidelines can be printed from the website.

Medical Management
Advance Directives

Advance directives are written instructions that:

- Give direction to health care Providers as to the provision of health care
- Provide for treatment choices when a person is incapacitated
- Are recognized under state law when signed by a competent person

There are three types of advance directives:

- A durable power of attorney for health care (durable power) allows the Member to name a patient advocate to act on behalf of the Member
- A living will allows the Member to state his or her wishes in writing but does not name a patient advocate
- A declaration for mental health treatment gives instructions about a Member’s future mental health treatment if the Member becomes unable to make those decisions. The instructions state whether the Member agrees or refuses to have the treatments described in the declaration with or without conditions and limitations

Anthem Blue Cross advance directives policies include:

- Respecting the rights of the Member to control decisions relating to his or her own medical care, including the decision to have provided, withheld or withdrawn the medical or surgical means or procedures calculated to prolong his or her life; this right is subject to certain interests of society, such as the protection of human life and the preservation of ethical standards in the medical profession
Chapter 10: MEDICAL MANAGEMENT

- Adhering to the Patient Self-Determination Act and maintaining written policies and procedures regarding advance directives; Providers must adhere to this Act and to all state and federal standards as specified in SSA 1902(a)(57), 1903(m)(1)(A), 42 CFR 438.6(i) and 42 CRF 489 subpart I
- Advising Members of their right to self-determination regarding advance directives
- Encouraging Members to request an advance directives form and education from their PCP at their first appointment
- Assisting Members with questions about an advance directives; no Anthem Blue Cross employee may serve as witness to an advance directives or as a Member’s authorized agent or representative
- While Members have the right to formulate an advance directives, an Anthem Blue Cross associate, a facility or a Provider may conscientiously object to an advance directives within certain limited circumstances if allowed by state law
- Having Member Services, Health Promotion, Provider Relations and/or Health Care Management Services staff review and update advance directives notices and education materials for Members on a regular basis
- Member materials will contain information, as applicable, regarding provisions for conscience objection. Materials explain the differences between institution-wide objections based on conscience and those that may be raised by individual physicians
- **Anthem Blue Cross** or the practitioner must issue a clear and precise written statement of this limitation to CMS and request a conscience protection waiver. The conscientious objection will be stated clearly and describes the following:
  - Describes the range of medical conditions or procedures affected by the conscience objection
  - Identifies the state legal authority permitting such objection
- Noting the presence of advance directives in the medical records when conducting medical chart audits

**Providers must:**

- Comply with the Patient Self-Determination Act requirements
- Make sure the first point of contact in the PCP’s office asks the Member if he or she has executed an advance directive
- Document in the Member’s medical record his or her response to an offer to execute any advance directive in a prominent place, including a do-not-resuscitate directive or the Provider and Member’s discussion and action regarding the execution or non-execution of an advance directive
- Ask Members who have executed an advance directive to bring a copy of the advance directive(s) to the PCP/Provider at the first point of contact
- Make an advance directive part of the Member’s medical record and put in a prominent place
  - The physician discusses potential medical emergencies with the Member and/or family/significant other and with the referring physician, if applicable
If an advance directive has not been executed, the first point of contact at the PCP/Provider’s office will ask the Member if he or she would like advance directive information. If the Member desires further information, Member advance directive education will be provided.

- Not discriminate or retaliate against a Member based on whether he or she has executed an advance directive


Psychiatric advance directive information may be found at the following website: [http://www.nrc-pad.org/content/view/41/25/](http://www.nrc-pad.org/content/view/41/25/).
CHAPTER 11: HOSPITAL AND ELECTIVE ADMISSION MANAGEMENT

Hospital and Elective Management
Overview

Anthem Blue Cross requires precertification of all inpatient elective admissions. The referring primary care or specialist physician is responsible for precertification.

The referring physician identifies the need to schedule a hospital admission and must submit the request to the Anthem Blue Cross Health Care Management Services department.

Requests for precertification with all supporting documentation should be submitted immediately upon identifying the inpatient request or at least 72 hours prior to the scheduled admission. This will allow Anthem Blue Cross to verify benefits and process the precertification request. For services that require precertification, Anthem Blue Cross makes case-by-case determinations that consider an individual’s health care needs and medical history, in conjunction with nationally recognized standards of care.

The hospital can confirm a precertification is on file by calling Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. (see the Anthem Blue Cross website and the Provider Inquiry Line section of this manual for instructions on use of the Provider Inquiry Line). If coverage of an admission has not been approved, the facility should call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. Anthem Blue Cross will contact the referring physician directly to resolve the issue.

Anthem Blue Cross is available 24 hours a day, 7 days a week to accept precertification requests. When a request is received from the physician via telephone or fax for medical services, the care specialist will verify eligibility and benefits. This information will be forwarded to the precertification nurse.

The precertification nurse will review the coverage request and the supporting medical documentation to determine the medical appropriateness of diagnostic and therapeutic procedures. When appropriate, the precertification nurse will assist the physician in identifying alternatives for health care delivery as supported by the Medical Director.

When the clinical information received is in accordance with the definition of medical necessity and in conjunction with nationally recognized standards of care, an Anthem Blue Cross reference number will be issued to the referring physician. All utilization guidelines must be supported by an individualized determination of medical necessity based on the Member’s needs and medical history.

If medical necessity criteria for the admission are not met on the initial review, the Medical Director will contact the requesting physician to discuss the case.
If the precertification documentation is incomplete or inadequate, the precertification nurse will notify the referring Provider to submit the additional necessary documentation.

If the Medical Director denies coverage of the request, the appropriate denial letter, including the appropriate appeal rights, will be mailed to the Member and Provider.

Providers will be held liable for all other inpatient denials issued. Any subsequent appeals should follow the correct process as outlined in the denial letter.

**Hospital and Elective Management**

**Emergent Admission Notification Requirements**

**Anthem Blue Cross** prefers immediate notification by network hospitals of emergent admissions. Network hospitals must notify **Anthem Blue Cross** of emergent admissions within one business day. **Anthem Blue Cross** Health Care Management Services staff will verify eligibility and determine benefit coverage.

**Anthem Blue Cross** is available 24 hours a day, 7 days a week to accept emergent admission notification via the Provider portal or by contacting the Provider services line at 1-855-817-5786.

Coverage of emergent admissions is authorized based on review by a concurrent review nurse. When the clinical information received meets nationally recognized standards of care, an **Anthem Blue Cross** reference number will be issued to the hospital.

If the notification documentation provided is incomplete or inadequate, **Anthem Blue Cross** will not approve coverage of the request but will notify the hospital to submit the additional necessary documentation.

If the Medical Director denies coverage of the request, the appropriate denial letter will be mailed to the Member and / or Provider, including the appropriate appeal rights depending on the nature of the denial.

**Hospital and Elective Management**

**Nonemergent Outpatient and Ancillary Services – Precertification and Notification Requirements**

**Anthem Blue Cross** requires precertification for coverage of selected nonemergent outpatient and ancillary services. Requests for precertification with all supporting documentation should be submitted immediately upon identifying the need for the request or at least 72 hours prior to the scheduled service.
To ensure timeliness of the decision, the following must be provided:

- Member name and ID number
- Name, telephone number and fax number of physician performing the elective service
- Name of the facility and telephone number where the service is to be performed
- Date of service
- Member diagnosis
- Name of elective procedure to be performed with CPT-4 code
- Medical information to support requested services (medical information includes current signs/symptoms, past and current treatment plans, response to treatment plans and medications)

Hospital and Elective Management

Inpatient Admission Reviews

All inpatient hospital admissions, including urgent and emergent admissions, will be reviewed within one business day. The Anthem Blue Cross utilization review clinician determines the Member’s medical status through communication with the hospital’s Utilization Review department. Appropriateness of the stay is documented, and concurrent review is initiated. Cases may be referred to the Medical Director who renders a decision regarding the coverage of hospitalization. Diagnoses meeting specific criteria are referred to the Medical Director for possible coordination by the care management program.

Hospital and Elective Management

Affirmative Statement about Incentives

Anthem Blue Cross requires associates who make Utilization Management (UM) decisions to adhere to the following principles:

- UM decision-making is based only on the appropriateness of care and service and existence of coverage.
- Anthem Blue Cross does not reward practitioners or other individuals for issuing denials of coverage or service.
- Financial incentives for Anthem Blue Cross UM decision makers do not encourage decisions that result in underutilization.

Hospital and Elective Management

Discharge Planning

Discharge planning is designed to assist the Provider in the coordination of a Member’s discharge when acute care (hospitalization) is no longer necessary. The Anthem Blue Cross concurrent review nurse or case manager (working with the Anthem Blue Cross Medical Director) will assist Providers and hospitals with the discharge planning process in accordance with requirements of the California Cal MediConnect program. At the time of admission and
during the hospitalization, the **Anthem Blue Cross** case manager will discuss discharge planning with the Provider, ICT, Member and/or Member advocate. When the Provider and/or ICT identifies medically necessary and appropriate services for the Member, **Anthem Blue Cross** will assist the Provider and the discharge planner in providing a timely and effective transfer to the next appropriate level of care or coordination of services. The Nurse or case manager will also assist the Member and/or member advocate with the following:

- Notification and participation of the Member’s ICT in discharge planning, coordination and reassessment as needed
- Identification of non-clinical supports and the role they serve in the Member’s treatment and aftercare plans
- Scheduling of discharge/aftercare appointments in accordance with the access and availability standards
- Identification of barriers to aftercare and the strategies developed to address such barriers
- Assurance that inpatient and 24-hour diversionary behavioral health providers provide a discharge plan following any behavioral health admission to ICT members
- Ensure that Members who require medication monitoring will have access to such services within fourteen (14) business days of discharge from a behavioral health inpatient setting
- Make best efforts to ensure a smooth transition to the next service or to the community
- Document all efforts related to these activities, including the Member’s active participation in discharge planning

During the transition period referenced above, **Anthem Blue Cross** may change a Member’s existing Provider only in the following circumstances:

- Member requests a change
- The Provider chooses to discontinue providing services to a member as currently allowed by Medicare and Medicaid
- **Anthem Blue Cross**, CMS or DHCS identify provider performance issues that affect a Member’s health and welfare
- The Provider is excluded under state or federal exclusion requirements
Hospital and Elective Management
Confidentiality Statement

Members have the right to privacy and confidentiality regarding their health care records and information in accordance with the California Cal MediConnect program and provisions of HIPAA concerning Members’ rights with respect to their protected health information and obligations of covered entities.

Utilization management, case management, discharge planning, quality management and claims payment activities are designed to ensure patient-specific information, particularly protected health information obtained during review, is kept confidential in accordance with applicable laws, including HIPAA. Information is used for the purposes defined above and shared only with entities who have the authority to receive such information and only with those individuals who need access to such information in order to conduct utilization management and related processes.

Providers must comply with all state and federal laws concerning privacy, confidentiality, accuracy and timely maintenance of health and other Member information. Providers must have policies and procedures regarding use and disclosure of health information and comply with applicable laws.

Hospital and Elective Management
Emergency Services

Anthem Blue Cross provides a 24-hour-a-day, 7-day-a-week Nurse HelpLine service with clinical staff to provide triage advice and referral and, if necessary, to make arrangements for treatment of the Member. The staff has access to qualified behavioral health professionals to assess behavioral health emergencies.

Anthem Blue Cross does not discourage Members from using the 911 emergency system nor does Anthem Blue Cross deny access to emergency services. Emergency services are provided to Members without requiring precertification. Any hospital or Provider calling for precertification for emergency services will be granted one immediately upon request. Emergency services coverage includes services needed to evaluate or stabilize an emergency medical condition. Criteria used to define an emergency medical condition are consistent with the prudent layperson standard and comply with federal and state requirements.

An emergency medical condition is defined as a physical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in the following: (1) placing the health of the
individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; and/or (3) serious dysfunction of any bodily organ or part.

Emergency response is coordinated with community services, including the police, fire and Emergency Medical Services (EMS) departments, juvenile probation, the judicial system, child protective services, chemical dependency, emergency services and local mental health authorities, if applicable.

When a Member seeks emergency services at a hospital, the determination as to whether the need for those services exists will be made for purposes of treatment by a physician licensed to practice medicine or, to the extent permitted by applicable law, by other appropriately licensed personnel under the supervision of or in collaboration with a physician licensed to practice medicine. The physician or other appropriate personnel will indicate in the Member’s chart the results of the emergency medical screening examination. **Anthem Blue Cross** will compensate the Provider for the screening, evaluations and examinations that are reasonable and calculated to assist the health care Provider to determine whether or not the patient’s condition is an emergency medical condition.

If there is concern surrounding the transfer of a patient (i.e., whether the patient is stable enough for discharge or transfer or whether the medical benefits of an unstable transfer outweigh the risks), the judgment of the attending physician(s) actually caring for the Member at the treating facility prevails and is binding on **Anthem Blue Cross**. If the emergency department is unable to stabilize and release the Member, **Anthem Blue Cross** will assist in coordination of the inpatient admission regardless of whether the hospital is network or non-network. All transfers from non-network to network facilities are to be conducted only after the Member is medically stable and the facility is capable of rendering the required level of care.

If the Member is admitted, the **Anthem Blue Cross** concurrent review nurse will implement the concurrent review process to ensure coordination of care.

**Hospital and Elective Management**

**Post-Stabilization Care Services**

Post-stabilization care services are covered services related to an emergency condition provided after a patient is stabilized to maintain the stabilized condition or improve or resolve the patient’s condition. Precertification is not required for emergency services in or out of the network. All emergency services are reimbursed at least at the Medicare network rate. **Anthem Blue Cross** will adjudicate emergency and post-stabilization care services that are medically necessary until the emergency condition is stabilized and maintained.
Hospital and Elective Management

Nonemergency Services

For routine, symptomatic, beneficiary-initiated outpatient appointments for primary preventive medical care, the request-to-appointment time must be no greater than 30 days, unless the Member requests a later time. For routine, symptomatic, beneficiary-initiated outpatient appointments for non-urgent primary medical care, the request-to-appointment time must be no greater than 30 calendar days, unless the member requests a later time. Primary medical, including dental care outpatient appointments for urgent conditions, must be available within 24 hours. For specialty outpatient referral and/or consultation appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than 21 days, unless the Member requests a later time. For outpatient scheduled appointments, the time the Member is seen must not be more than 30 minutes after the scheduled time, unless the Member is late. For routine outpatient diagnostic laboratory, diagnostic imaging and other testing appointments, the request-to-appointment time must be consistent with the clinical urgency but no greater than seven days, unless the Member requests a later time. For urgent outpatient diagnostic laboratory, diagnostic imaging and other testing, appointment availability will be consistent with the clinical urgency but no greater than 24 hours. The timing of scheduled follow-up outpatient visits with practitioners must be consistent with the clinical need.

Hospital and Elective Management

Urgent Care

Anthem Blue Cross requests its Members to contact their PCP in situations when urgent, unscheduled care is necessary. Precertification with Anthem Blue Cross is not required for a Member to access an urgent care center.
CHAPTER 12: MEMBER MANAGEMENT SUPPORT

Member Management Support
Welcome Call

As part of our member management strategy, Anthem Blue Cross offers a welcome call to new Members. Additionally, Member Services representatives offer to assist Members with any current needs, such as scheduling an initial checkup.

Member Management Support
Appointment Scheduling

Anthem Blue Cross, through its participating Providers, ensures Members have access to primary care services for routine, urgent and emergency services and to specialty care services for chronic and complex care. Providers will respond to a Member’s needs and requests in a timely manner. The Primary Care Provider (PCP) should make every effort to schedule Members for appointments using the PCP Access and Availability guidelines.

Member Management Support
Nurse HelpLine

The Anthem Blue Cross Nurse HelpLine is a service designed to support the Provider by offering information and education about medical conditions, health care and prevention to Members after normal physician practice hours. The Nurse HelpLine provides triage services and helps direct Members to appropriate levels of care. The Anthem Blue Cross Nurse HelpLine telephone number is 1-855-817-5786 and is listed on the Member’s ID card. This ensures Members have an additional avenue of access to health care information when needed.

Features of the Nurse HelpLine include:

- Availability 24 hours a day, 7 days a week for crisis and triage services
- Information based upon nationally recognized and accepted guidelines
- Free translation services for over 200 different languages and for Members with difficulty hearing
- Education for Members about appropriate alternatives for handling nonemergent medical conditions
- Member assessment reports faxed to Providers’ offices within 24 hours of the call
Member Management Support
Care Management Support

The Anthem Blue Cross Care Management Support is a service designed to support the Provider as well as the Member. Providers can speak with a Case Manager about a specific Member’s care plan or general questions concerning care management. Members have access to information regarding all covered services. The Anthem Blue Cross Care Management Support is available 24 hours a day, 7 days a week through Cal MediConnect Customer Care at 1-855-817-5786.

Member Management Support
Interpreter Services

Anthem Blue Cross provides your office with interpreter services for your Anthem Blue Cross Cal MediConnect Plan Members. Services are available 24 hours a day, 7 days a week and include over 200 languages, as well as services for Members who are deaf or hard of hearing. Interpretation is a free service offered to our network Providers by calling Cal MediConnect Customer Care at Cal MediConnect Customer Care at 1-855-817-5786.

Member Management Support
Health Promotion

Anthem Blue Cross strives to improve healthy behaviors, reduce illness and improve the quality of life for our Members through comprehensive programs. Educational materials are developed or purchased and disseminated to our Members, and health education classes are coordinated with community organizations and network Providers contracted with Anthem Blue Cross

Anthem Blue Cross manages projects that offer our Members education and information regarding their health. Ongoing projects include:

- Creation and distribution health education tools used to inform Members of health promotion issues and topics
- Health Tips on Hold (educational telephone messages while the Member is on hold)
- Health education programs offered to Members
- Development of health education curricula and procurement of other health education tools (e.g., breast self-exam cards)
- Relationship development with community based organizations to enhance opportunities for Members
Member Management Support

Member Satisfaction

Anthem Blue Cross periodically surveys Members to measure overall customer satisfaction, including satisfaction with the care received from Providers. Anthem Blue Cross reviews survey information and shares the results with network Providers.

Members are also surveyed by CMS twice a year through the CAHPS and HOS surveys. The results of both CMS surveys are part of the Anthem Blue Cross HEDIS and star ratings. Anthem Blue Cross encourages its participating Providers to encourage Members to actively participate in their health care, to receive preventive services timely and to improve their quality of life by following the Provider’s treatment plan. See the Centers for Medicare & Medicaid Services Star Ratings section of this manual.
CHAPTER 13: CLAIMS SUBMISSION and ADJUDICATION PROCEDURES

Claims Submission and Adjudication Procedures

Claims - Billing and Reimbursement

Clean claims for members are generally adjudicated within 30 calendar days from the date Anthem Blue Cross receives the claim. However, clean claims from providers of Medicaid covered services (e.g., Nursing Facilities, Long Term Services and Supports, Community Behavioral Health) will be processed within 45 days of receipt of the clean claim.

Anthem Blue Cross will pay interest charges on claims in compliance with requirements set forth in in Code of California and the Demonstration between CMS, the State and Anthem Blue Cross contract as applicable.

For non-clean claims, the Provider receives written notification identifying the claim number, the reason the claim could not be processed, the date the claim was received by Anthem Blue Cross and the information required from the Provider in order to adjudicate the claim. Anthem Blue Cross produces and mails an Explanation of Payment (EOP) on a twice weekly basis. The EOP delineates for the Provider the status of each claim that has been paid or denied during the previous week.

Reimbursement by Anthem Blue Cross constitutes payment in full. Balance billing the Cal MediConnect Member is prohibited per the participating Provider.

Anthem Blue Cross follows Strategic National Implementation Process (SNIP) level 1 through 6 editing for all claims received in accordance with HIPAA. Provider must bill all electronic and paper submitted claims and use HIPAA-compliant billing codes. When billing codes are updated, the Provider is required to use appropriate replacement codes for submitting claims for covered services. An amendment to the participating Provider Agreement will not be required to replace such billing codes. Anthem Blue Cross will not reimburse any claims submitted using noncompliant billing or SNIP codes.

Providers resubmitting claims for corrections must clearly mark the claim “Corrected Claim.” Failure to mark the claim appropriately may result in denial of the claim as a duplicate. Corrected claims must be received within the applicable timely filing requirements of the originally submitted claim.
Claims Submission and Adjudication Procedures

Claims Status

Providers should visit the Anthem Blue Cross website located at www.anthem.com/CA or call the automated Provider Services at Cal MediConnect Customer Care at 1-855-817-5786 to check claims status.

Providers are encouraged to review their EDI reports from the EDI vendors and address any issues with claims submissions such as addressing rejected claims.

Claims Submission and Adjudication Procedures

Provider Claims

Providers should submit claims to Anthem Blue Cross as soon as possible after service is rendered. Providers are encouraged to submit their claims electronically as the preferred method for claims submission. Providers must submit electronic claims using the 837I (Institutional) or 837P (Professional) standard format. Provider must use the industry standard claim form CMS-1450, also known as the UB-04 or CMS-1500 (02-12) for all paper submissions.

Claims Submission and Adjudication Procedures

CMS-1500 (08-05)

9. OTHER INSURED’S NAME (Last Name, First Name, Middle Initial)
   a. OTHER INSURED’S POLICY OR GROUP NUMBER
   b. OTHER INSURED’S DATE OF BIRTH
   c. EMPLOYER’S NAME OR SCHOOL NAME
   d. INSURANCE PLAN NAME OR PROGRAM NAME

25. FEDERAL TAX I.D. NUMBER
    SSN   EIN

33. BILLING PROVIDER INFO & PHONE NUMBER
    (   )
Hospitals
CMS-1450, also known as the UB-04

5. FEDERAL TAX NUMBER

51. HEALTH PLAN I.D.

Claims Submission and Adjudication Procedures
Coordination of Benefits
For the Anthem Blue Cross Cal MediConnect Plan, Anthem Blue Cross will coordinate and process the claim upon initial submission from the Provider.

Claims Submission and Adjudication Procedures
Electronic Submission
Anthem Blue Cross encourages the submission of claims electronically through Electronic Data Interchange (EDI). Providers must submit claims within the timely filing limits from the date of discharge for inpatient services or from the date of service for outpatient services. Nursing facilities should submit claims within timely filing limits from the date the service is provided for Long Term Services and Supports.

<table>
<thead>
<tr>
<th>Professional</th>
<th>Institutional</th>
<th>Dental</th>
</tr>
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<tbody>
<tr>
<td>47198</td>
<td>47198</td>
<td>058916206CMSCOS</td>
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</tbody>
</table>

The advantages of electronic claims submission are as follows:
- Facilitates timely claims adjudication
- Acknowledges receipt and rejection notification of claims electronically
- Improves claims tracking
- Improves claims status reporting
- Reduces adjudication turnaround
- Eliminates paper
- Improves cost-effectiveness
- Allows for automatic adjudication of claims
The guide for EDI claims submission is located at www.anthem.com/CA log into the secure site by entering your user name and password. The EDI Claim Submission Guide includes additional information related to the EDI claim process.

To initiate the electronic claims submission process or obtain additional information, contact the Anthem Blue Cross E Solutions EDI Hotline at 1-800-470-9630.

Claims Submission and Adjudication Procedures
EDI Submission for Corrected Claims

For corrected professional (837P) claims submitted via EDI claim professional, Providers should use one the following frequency codes to indicate a correction was made to a previously submitted and adjudicated claim:

- 7 – Replacement of Prior Claim
- 8 – Void/Cancel Prior Claim

Note: A full definition of each code and confirmation of the use of these codes on a professional claim can be found on the National Uniform Billing Committee (NUBC) website www.nubc.org.

Indicator Placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type Code)
Value: 7, 8

For corrected institutional (837I) claims submitted via EDI, Providers should use one of the following Bill Type Frequency Codes to indicate a correction was made to a previously submitted and adjudicated claim:

- OXX5 – Late Charges Only Claim
- OXX7 – Replacement of Prior Claim
- OXX8 – Void/Cancel Prior Claim

Note: A full definition of each code can be referenced on Pages II-111 through II-114 of the Ingenix UB04 Billing Manual.
Indicator Placement:
Loop: 2300 (Claim Information)
Segment: CLM 05-03 (Claim Frequency Type Code)
Value: 5, 7, 8

Claims Submission and Adjudication Procedures

Paper Claim Submission

Providers also have the option of submitting paper claims. **Anthem Blue Cross** uses Optical Character Recognition (OCR) technology as part of its front-end claims processing procedures. The benefits include the following:

- Faster turnaround times and adjudication
- Claims status availability within five days of receipt
- Immediate image retrieval by **Anthem Blue Cross** staff for claims information, allowing more timely and accurate response to Provider inquiries

To use OCR technology, claims must be submitted on original red claim forms (not black and white or photocopied forms) and laser printed or typed (not handwritten) in a large, dark font. Providers must submit a properly completed UB-04 or CMS-1500 (08-05) within 365 days from the date of discharge for inpatient services or from the date of service for outpatient services, except in cases of coordination of benefits/subrogation or in cases where a Member has retroactive eligibility. For cases of coordination of benefits/subrogation, the time frames for filing a claim will begin on the date the third party documents resolution of the claim.

In accordance with the implementation timelines set by CMS and NUCC, **Anthem Blue Cross** requires the use of the new CMS-1500 (08-05) for the purposes of accommodating the National Provider Identifier (NPI).

In accordance with the implementation timelines set by CMS and NUBC, **Anthem Blue Cross** requires the use of the new UB-04 CMS-1450 for the purposes of accommodating the NPI.

CMS-1500 (08-05) and UB-04 CMS-1450 must include the following information (HIPAA-compliant where applicable):

- Patient’s ID number
- Patient’s name
- Patient’s date of birth
- ICD-10 diagnosis codes/revenue codes
- Date of service
- Place of service
- Description of services rendered CPT-4 codes/HCPC codes/DRGs
Chapter 13: CLAIMS SUBMISSION AND ADJUDICATION PROCEDURES

Anthem Blue Cross
Anthem Blue Cross Cal MediConnect Plan

- Itemized charges
- Days or units
- Provider tax ID number
- Provider name according to contract
- **Anthem Blue Cross** Provider number
- NPI of billing Provider when applicable
- Name of ordering physician
- NPI of ordering physician when applicable
- Name of performing physician
- NPI of performing Provider when applicable
- State Medicaid ID number
- Coordination of Benefits/other insurance information
- Authorization/precertification number or copy of authorization/precertification
- Name of referring physician
- NPI of referring physician when applicable
- Any other state-required data

**Anthem Blue Cross** cannot accept claims with alterations to billing information. Claims that have been altered will be returned to the Provider with an explanation of the reason for the return. **Anthem Blue Cross** will not accept claims from those Providers who submit entirely handwritten claims.

Paper claims must be submitted within the timely filing limit of 365 days from the date of service.

Submit paper claims to the following address:

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

**Claims Submission and Adjudication Procedures**

**Encounter Data**

**Anthem Blue Cross** has established and maintains a system to collect Member encounter data. Due to reporting needs and requirements, network Providers who are reimbursed by capitation must send encounter data to **Anthem Blue Cross** for each Member encounter. Encounter data can be submitted through EDI submission methods or on a CMS-1500 (08-05) or a UB-04 claim form, unless other arrangements are approved by **Anthem Blue Cross**. Data will be submitted in a timely manner but no later than 12 months from the date of service.
The encounter data will include the following:

- **Anthem Blue Cross Cal MediConnect Plan** Member ID number
- **Anthem Blue Cross Cal MediConnect Plan** Member name (first and last name)
- **Anthem Blue Cross Cal MediConnect Plan** Member date of birth
- Provider name according to contract
- NPI Provider number
- Coordination of benefit information
- Date of encounter
- Diagnosis code
- Types of services provided (utilizing current procedure codes and modifiers if applicable)
- Provider tax ID number and state Medicaid ID number

Encounter data should be submitted to the address provided on the previous page.

Through claims and encounter data submissions, Healthcare Effectiveness Data and Information Set (HEDIS) information is collected. This includes but is not limited to the following:

- Preventive services (e.g., childhood immunization, mammography, Pap smears)
- Prenatal care (e.g., low birth weight, general first trimester care)
- Acute and chronic illness (e.g., ambulatory follow-up and hospitalization for major disorders)

Compliance is monitored by the **Anthem Blue Cross** utilization and quality improvement staff, coordinated with the Medical Director and reported to the Quality Management Committee on a quarterly basis. The PCP is monitored for compliance with reporting of utilization. Lack of compliance will result in training and follow-up audits and could result in termination.
Claims Submission and Adjudication Procedures

**Claims Adjudication**

*Anthem Blue Cross* is dedicated to providing timely adjudication of Provider claims for services rendered to Members. All network and non-network Provider claims submitted for adjudication are processed according to generally accepted claims coding and payment guidelines. These guidelines comply with industry standards as defined by the CPT-4 and ICD-10 manuals. Institutional claims should be submitted using EDI submission methods or a CMS-1450 (UB-04) and Provider claims using the CMS-1500.

Providers must use HIPAA-compliant billing codes when billing *Anthem Blue Cross*. This applies to both electronic and paper claims. When billing codes are updated, the Provider is required to use appropriate replacement codes for submitted claims. *Anthem Blue Cross* will not pay any claims submitted using noncompliant billing codes.

*Anthem Blue Cross* reserves the rights to use code-editing software to determine which services are considered part of, incidental to or inclusive of the primary procedure. The automated claims auditing system verifies the coding accuracy of claims for CPT and Healthcare Common Procedure Coding System (HCPCS) procedures. This system ensures the same auditing criteria are applied across all claims. Editing decisions are supported by online medical coding policy statements published by CMS as a part of the National Correct Coding Initiative (NCCI, also known as CCI).

For claims payment to be considered, Providers must adhere to the following time limits:

- Submit claims within the number of days specified from the date the service is rendered, or for inpatient claims filed by a hospital, within the number of days specified from the date of discharge.
- In the case of other insurance, submit the claim within the number of days specified for each market after receiving a response from the third-party payer.
- Claims for Members whose eligibility has not been added to the state’s eligibility system must be received within 365 days from the date the eligibility is added and *Anthem Blue Cross* is notified of the eligibility/enrollment.
- Claims submitted after the market specific timely filing deadline will be denied.

After filing a claim with *Anthem Blue Cross*, review the twice weekly EOP. If the claim does not appear on an EOP within 30 business days as adjudicated or you have no other written indication the claim has been received, check the status of your claim by using the *Anthem Blue Cross* website at www.anthem.com/CA or by calling Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. If the claim is not on file with *Anthem Blue Cross*, resubmit your claim within 365 days from the date of service. If filing electronically, check the confirmation reports for acceptance of the claim you receive from your EDI or practice.
Claims Submission and Adjudication Procedures

Clean Claims Payment

A clean claim is a request for payment for a service rendered by a Provider that is:

- Submitted in a timely manner
- Free of defects
- Submitted on a HIPAA-compliant standard claim form CMS-1500 (02-12) or CMS-1450 (UB-04) or successor forms thereto or the electronic equivalent
- Does not require developing, outreach to an external source, adjustment or alteration by the Provider or by a third party in order to be processed and paid by Anthem Blue Cross

Clean claims are typically adjudicated within 30 calendar days of receipt or within 14 days, as required for Medicaid services. Anthem Blue Cross will pay all applicable interest as required by law on clean claims not adjudicated within the timeframes specified above.

Anthem Blue Cross produces and mails an explanation of payment (EOP) twice per week. The EOP delineates for the Provider the status of each claim adjudicated during the previous payment cycle.

Electronic claims determined to be unclean will be returned to the Anthem Blue Cross contracted clearinghouse that submitted the claim.

In accordance with CMS requirements, Anthem Blue Cross will adjudicate at least 90 percent of all clean claims within 30 calendar days of the date of receipt. However, clean claims from providers of Medicaid covered services (e.g., Nursing Facilities, Long Term Services and Supports, Community Behavioral Health) should be processed within 45 days of receipt of the clean claim.
Claims Submission and Adjudication Procedures

Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA)

Anthem Blue Cross offers Electronic Funds Transfer (EFT) and Electronic Remittance Advice (ERA) with online viewing capability. Providers can elect to receive Anthem Blue Cross payments electronically through direct-deposit to their bank account. In addition, Providers can select from a variety of remittance information options, including:

- HIPAA-compliant data file for download directly to your practice management or patient accounting system
- Paper remittance printed and mailed by Anthem Blue Cross

Some of the benefits Providers may experience include:

- Faster receipt of payments from Anthem Blue Cross
- The ability to generate custom reports on both payment and claim information based on the criteria specified
- Online capability to search claims and remittance details across multiple remittances
- Elimination of the need for manual entry of remittance information and user errors

To register for ERA/EFT, please visit our website at www.anthem.com/CA

Specialist Reimbursement

Specialty care Providers must obtain Anthem Blue Cross approval prior to rendering or arranging any treatment that is beyond the specific treatment authorized or beyond the scope permitted under this program.

Specialty care Provider services will be covered only when there is documentation of appropriate notification or prior authorization as appropriate, and receipt of the required claims and encounter information to Anthem Blue Cross

Reimbursement Policies

Reimbursement policies serve as a guide to assist you with accurate claims submissions and outline the basis for reimbursements when services are covered by the Member’s Anthem Blue Cross Cal MediConnect Plan. The determination that a service, procedure, item, etc. is covered under a Member's benefit plan is not a determination that you will be reimbursed. Services must meet authorization and medical necessity guidelines appropriate to the procedure and diagnosis. You must follow proper billing and submission guidelines. You are required to use industry standard, compliant codes on all claims submissions. Services should be billed with CPT.
codes, HCPCS codes and/or revenue codes. The codes denote the services and/or procedures performed. The billed code(s) are required to be fully supported in the medical record and/or office notes. Unless otherwise noted within the policy, our policies apply to both participating and nonparticipating Providers and facilities.

The **Anthem Blue Cross** reimbursement policies are based on nationally accepted industry standards and coding principles. These policies may be superseded by mandates in Provider or state contracts, or state, federal or CMS requirements. System logic or setup may prevent the loading of policies into the claims platforms in the same manner as described; however, **Anthem Blue Cross** strives to minimize these variations.

We reserve the right to review and revise our policies periodically when necessary. When there is an update, we will publish the most current policies to our Provider website under the Quick Tools menu.

**Claims Submission and Adjudication Procedures**

**Reimbursement Hierarchy**

Claims submitted for payments must meet all aspects of criteria for reimbursements. The reimbursement hierarchy is the order of payment conditions that must be met for a claim to be reimbursed. Conditions of payment could include benefits coverage, medical necessity, authorization requirements or stipulations within a reimbursement policy. Neither payment rates nor methodologies are considered to be conditions of payments.

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**Step 1**
**Benefit Coverage**

**Step 2**
**Medical Necessity or Clinical Criteria**

**Step 3**
**Reimbursement Policy**

**Step 4**
**Payment Rate or Methodology as determined by contract or requirements**

---

**Claims Submission and Adjudication Procedures**

**Review Schedule and Updates**

Reimbursement policies undergo reviews every two years for updates to state contracts or state, federal or CMS requirements. Additionally, updates may be made at any time if we are notified of a mandated change or due to an **Anthem Blue Cross** business decision. When there is an update, we will publish the most current policies to our Provider website.
Claims Submission and Adjudication Procedures

Reimbursement by Code Definition

Anthem Blue Cross allows reimbursements for covered services based on their procedure code definitions or descriptors, as opposed to their appearance under particular CPT categories or sections unless otherwise noted by state or Provider contracts, or state, federal or CMS requirements. There are seven CPT sections:

- Evaluation and management
- Anesthesia
- Surgery
- Radiology (nuclear medicine and diagnostic imaging)
- Pathology and laboratory
- Medicine
- Temporary codes for emerging technology, services or procedures

At times, procedure codes are located in particular CPT categories when those procedures may not as a general understanding be classified within that particular category (e.g., venipuncture is located in the CPT surgical section but is not considered to be a surgical procedure).

Claims Submission and Adjudication Procedures

Documentation Standards for and Episode of Care

When we request clinical documentation from you to support claims payments for services, you must ensure the information provided to us:

- Identifies the Member
- Is legible
- Reflects all aspects of care

To be considered complete, documentation for episodes of care will include at a minimum the following elements:

- Patient identifying information
- Consent forms
- Health history, including applicable drug allergies
- Types and dates of physical examinations
- Diagnoses and treatment plans for individual episodes of care
- Physician orders
- Face-to-face evaluations
- Progress notes
- Referrals
- Consultation reports
- Laboratory reports
- Imaging reports (including X-ray)
- Surgical reports
- Admission and discharge dates and instructions
- Preventive services provided or offered appropriate to the Member’s age and health status
- Evidence of coordination of care between primary and specialty physicians

Refer to the standard data elements to be included for specific episodes of care as established by The Joint Commission (TJC), formerly the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). A single episode of care refers to continuous care or a series of intervals of brief separations from care to a Member by a Provider or facility for the same specific medical problem or condition. Documentation for all episodes of care must meet the following criteria:

- Is legible to someone other than the writer
- Contains information that identifies the Member on each page in the medical record
- Contains entries in the medical record that are dated and include author identification (e.g., handwritten signatures, unique electronic identifiers or initials)

**Claims Submission and Adjudication Procedures**

**Other Documentation Not Related to the Member**

Other documentation not directly related to the Member but relevant to support clinical practice may be used to support documentation regarding episodes of care, including:

- Policies, procedures and protocols
- Critical incident/occupational health and safety reports
- Statistical and research data
- Clinical assessments
- Published reports/data

**Anthem Blue Cross** may request that you submit additional documentation, including medical records or other documentation not directly related to the Member, to support claims you submit. If documentation is not provided following the request or notification or if documentation does not support the services billed for the episode of care, we may:

- Deny the claim
- Recover and/or recoup monies previously paid on the claim

**Anthem Blue Cross** is not liable for interest or penalties when payment is denied or recouped because the Provider fails to submit required or requested documentation.
Claims Submission and Adjudication Procedures

Overpayment Process

Refund notifications may be identified either by Anthem Blue Cross Cost Containment Unit (CCU) or the Provider. The CCU researches and notifies the Provider of an overpayment by requesting a refund check. The Provider may also identify an overpayment and proactively submit a refund check to reconcile the overpayment amount.

Once an overpayment has been identified, Anthem will notify the Provider of the overpayment. The Provider will submit a Refund Notification Form along with the refund check. If a Provider identified the overpayment and returns the Anthem Blue Cross check, please include a completed Refund Notification Form specifying the reason for the return. This form can be found on the Provider website at www.anthem.com/CA. Submission of the Refund Notification Form will allow the CCU to process and reconcile the overpayment in a timely manner. Once the CCU has reviewed the overpayment, you will receive a confirmation letter explaining the details of the reconciliation. For questions regarding the refund notification procedure, please call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786.

Anthem Blue Cross uses an automated claims auditing system to ensure claims are adjudicated in accordance with industry billing and reimbursement standards. Claims auditing software ensures compliance with an ever-widening array of edits and rules as well as consistency of payment for Providers, by ensuring correct coding and billing practices are being followed. Using a sophisticated auditing logic, our code editing system determines the appropriate relationship between thousands of medical, surgical, radiology, laboratory, pathology and anesthesia codes and processes those services according to the NCCI. NCCI was implemented to promote national correct coding methodologies and to control improper coding leading to inappropriate payment. NCCI code pair edits are automated prepayment edits that prevent improper payment when certain codes are submitted together for Part B-covered services.

In addition to code pair edits, the NCCI includes a set of edits known as Medically Unlikely Edits (MUEs). An MUE is a maximum number of Units of Service (UOS) allowable under most circumstances for a single HCPCS/CPT code billed by a Provider on a date of service for a single beneficiary.
Claims Submission and Adjudication Procedures

Administrative Appeals

Please reference the notification letter received for the proper dispute/appeal process to submit your request. Note the process for appeals is different depending on whether or not the Member can be held liable for any payments (Member liability).

Claims Submission and Adjudication Procedures

Member Liability Appeals

If a Provider appeals a decision rendered with Member liability, then the appeal follows the Member Liability Appeals process and is handled by the Complaints, Appeals and Grievance department. See Member Liability Appeals process.

Claims Submission and Adjudication Procedures

Provider Liability Appeals

A Provider liability appeal is a request for Anthem Blue Cross to review a decision by Anthem Blue Cross Health Care Management Services to deny payment (without Member liability) for services already rendered. To submit a request, send in a copy of the original denial letter received along with all medical records. The Provider is responsible for sending in all necessary information, and the appeal will be reviewed and a determination rendered based on the information provided.

Claims Submission and Adjudication Procedures

Provider Payment Disputes

If you believe Anthem Blue Cross has not paid for your services according to the terms of your Provider Agreement, submit a request using the Appeals Form located online under Forms at www.anthem.com/CA

Providers will not be penalized for filing an appeal or payment dispute.

Submit Provider liability appeals/payment disputes to:

Provider Liability Appeals/Payment Disputes
Anthem Blue Cross
P.O. Box 61599
Virginia Beach, VA 23466

The Provider Disputes Unit will receive, distribute and coordinate all payment disputes and appeals.
1. Submit a written request with supporting documentation, such as an EOP and a copy of the claims or denial letter received along with other written documentation; a full explanation of the dispute/appeal is required and must be submitted within 120 days of when **Anthem Blue Cross** notice of initial determination was generated or we will not accept the request; the Provider is responsible to submit all necessary documentation at the time of the request.

2. The **Anthem Blue Cross** Claims department conducts the review, and/or the health plan Medical Director reviews the second level dispute if medical information is involved; if additional information is submitted that would support payment, the denial is overturned.

3. An internal review is conducted and results communicated in a written decision to the Provider within 45 calendar days; the written decision includes:
   - A statement of the Provider's dispute
   - The reviewer’s decision along with a detailed explanation of the contractual and/or medical basis for such decision
   - A description of the evidence or document that supports the decision
CHAPTER 14: PROVIDER COMPLAINT AND GRIEVANCE PROCEEDURES

Provider Complaint and Grievance Procedures

Overview

Anthem Blue Cross has a formal process for the handling of disputes pertaining to administrative issues and nonpayment-related matters. For payment disputes, see Provider Payment Disputes. For Medicare Member liability appeals, see Member Appeals. Providers may access this process by filing a written grievance. Provider grievances will be resolved fairly and consistent with Anthem Blue Cross policies and covered benefits.

Providers are not penalized for filing complaints. Any supporting documentation should accompany the complaint and be forwarded to:

Provider Liability Appeals/Payment Disputes
Anthem Blue Cross
P.O. Box 61599
Virginia Beach, VA 23466

Provider Complaint and Grievance Procedures

Provider Obligations and Notifications

Denial notification and Member complaints, appeals AND grievances
Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS) and Anthem Blue Cross requirements concerning issuing letters and notices.

Skilled Nursing Facilities and Home Health Agencies
The Notice of Medicare Non-Coverage (NOMNC) is a statutorily required notice issued to Members to alert them of a discontinuation of skilled nursing facility, comprehensive outpatient rehabilitation facility or home health services. This notice explains it has been determined that continued coverage after a specific effective date will no longer be covered by the plan. At least two days prior to discharge, or no later than the next to last time services are furnished, a NOMNC should be issued to a Member. This notice informs the Member his or her stay or visits no longer meet coverage criteria and will end in two days or after two visits. In most cases, the notice is required to be issued by the Provider, and Anthem Blue Cross is required to ensure proper delivery and that the Member’s signature is obtained. The Member’s signature is not an agreement with the denial; however, it is documentation he or she has received the notification. If a Member refuses to sign the notice, the Provider may contact the Member’s representative to have that person sign. If no representative is available, the Provider may annotate the notice to indicate the refusal and document that notification was provided to the Member, but the Member refused to sign. If a representative can be contacted, the representative should sign the notice. If in-person notification cannot be provided to a representative, he or she can be contacted by telephone to advise him or her of the notice and appeal rights. If agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). The notice should be annotated by the person.
providing the notification to the representative indicating the date, time, person name, relation to the Member, telephone number called and that the notice was read to the representative, including all appeal rights. If a Member (or representative) elects to exercise his or her right to an immediate review, the Member (or representative) must submit a request to the appropriate Quality Improvement Organization (QIO) for the state by the deadline indicated in the notice. The Provider is responsible for submitting any documents or medical records as requested by the QIO or Anthem Blue Cross Medicare Complaints, Appeals and Grievance department within the time frame indicated on the request.

Hospitals

The Important Message from Medicare (IMM) is a statutorily required notice issued to Medicare Advantage Members to alert them of a discontinuation of acute inpatient hospital services. Within two days after an admission or at the preadmission visit (but not more than seven calendar days in advance of the admission), the hospital providing the inpatient services is required to issue the IMM. This statutorily required notice explains the Medicare beneficiary’s rights as a hospital inpatient, including discharge appeal rights. The hospital is required to deliver the notice in person and obtain the signature of the Member or representative and provide a copy at that time. The hospital is also responsible for ensuring the Member can comprehend the contents of the notice before obtaining the signature, should explain the notice if necessary and be able to answer any questions about the notice. Notices should not be delivered while the Member is receiving emergency treatment but should be delivered once the patient is stable. If a Member refuses to sign the notice, the hospital may annotate the notice to indicate the refusal and document notification was attempted. If in-person notification cannot be provided to a representative, the hospital is responsible for telephonically contacting the representative to advise him or her of the appeal rights, or, if agreed by both parties, the notice can be emailed or faxed (in accordance with HIPAA privacy and security requirements). Prior to discharge (but not more than two days in advance of discharge), the hospital must deliver another copy of the signed notice to the Member or representative in person. If the notice is being given on the day of discharge, the Member must be provided at least four hours to consider his or her rights and to request the QIO review. Hospitals should not routinely provide the notice on the day of discharge. If the Member requests additional information on the discharge, the detailed notice can be issued prior to an immediate review request being initiated. If discharge occurs within two calendar days of the original notice, no additional copy needs to be delivered. If a Member elects to exercise his or her right to an immediate review, he or she must submit a request to the appropriate QIO, as outlined in the notice, by midnight of the day of discharge either verbally or in writing, before that person leaves the hospital.

In-office Denials

There may be situations where a Member disagrees with the Provider’s decision about a request for service or a course of treatment. At each patient encounter with a Coordinated Care Member, the Provider must notify the Member of his or her right to receive, upon request, a detailed written notice from Anthem Blue Cross regarding the Member’s services.
Chapter 14: PROVIDER COMPLAINT AND GRIEVANCE PROCEDURES

The Provider’s notification must provide the Member with the information necessary to contact Medicare or DHCS. If a Member (or Provider) requests us to provide a detailed notice of a Provider’s decision to deny a service in whole or part, we must give the Member a written notice of the determination.

Precertification
Providers are responsible for obtaining precertification from Anthem Blue Cross before performing certain procedures or when referring Members to non-contracted Providers. Please refer to the Summary of Benefits document for those procedures that require precertification or call Provider Services at Cal MediConnect Customer Care at 1-855-817-5786. Anthem Blue Cross will render a determination on the request within the appropriate time frame and provide notification of the decision. Requests that are denied will generate a notice that includes the denial rationale and applicable appeal rights. Members will receive a denial letter as well that includes appeal rights. Denials that are the result of contractual issues between Anthem Blue Cross and the Provider will not generate a Member denial letter.

- An initial organization determination is any determination (e.g., an approval or denial) made by Anthem Blue Cross for coverage of medical services
- An initial coverage determination is any determination (e.g., an approval or denial) made by Anthem Blue Cross for coverage of prescription drugs.

Appeals (Both Member and Provider Appeals)
Providers must cooperate with Anthem Blue Cross and with Members in providing necessary information to resolve the appeals within the required time frames. Providers must provide the pertinent medical records and any other relevant information upon request and when initiating an appeal. In some instances, Providers must provide the records and information very quickly in order to allow Anthem Blue Cross to make an expedited decision. Your participation in and the Member’s election of the Coordinated Care plan are an indication of consent to release those records as part of the health care operations.

Provider Complaint and Grievance Procedures

Administrative Appeals – Provider Liability Appeals / Provider Claim Disputes
Appeals or claim disputes that are the result of contractual issues between the Provider and Anthem Blue Cross carry no Member liability, and the Member is held harmless for any payment. It is important to follow the directions in the denial letter issued to ensure the proper appeals process is followed. The Provider liability appeals process is located under the section titled Provider Payment Disputes. Provider liability appeals and payment disputes are outlined in the Administrative Appeals section.
Provider Complaint and Grievance Procedures

Member Liability Appeals

A Member appeal is the type of request a Member (or authorized representative) makes when the Member wants Anthem Blue Cross to reconsider and change an initial coverage/organization determination (by Anthem Blue Cross or a Provider) about what services, benefits or prescription drugs are necessary or covered or whether Anthem Blue Cross will reimburse for a service, a benefit or a prescription drug.

A Member may appeal:

- An adverse initial organization determination by Anthem Blue Cross or a Provider concerning authorization for or termination of coverage of a health care service
- An adverse initial organization determination by Anthem Blue Cross concerning reimbursement for a health care service
- An adverse initial organization determination by Anthem Blue Cross concerning a refusal to reimburse for a health service already received if the refusal would result in the Member being financially liable for the service
- An adverse coverage determination by Anthem Blue Cross or a Provider concerning authorization for prescription drugs

Appeals must be filed within 60 days of the Anthem Blue Cross notification of the denial. The request may be made telephonically or in writing.

If the normal time period for an appeal could jeopardize the Member’s life, health or ability to regain maximum function (the same expedited criteria used in initial decisions), the Member or the Member’s physician can request an expedited appeal. Such appeals generally are resolved within 72 hours, unless it is in the Member’s interest to extend this time period. If a physician requests the expedited appeal and indicates the case meets the expedited criteria, Anthem Blue Cross will automatically expedite the appeal.

Appeals should be sent to:

Complaints, Appeals and Grievances Department
Anthem Blue Cross
P.O. Box 61116
Virginia Beach, VA 23466-1599
Phone: 1-855-817-5787
Fax: 1-855-856-1724

Providers may have to complete an Appointment of Representative Form to submit an appeal on behalf of a Cal MediConnect Member, unless the request is for an expedited appeal. The
Appointment of Representative Form can be found online and downloaded at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf. Providers can also obtain a signed written statement from the Medicare Member.

### Provider Complaint and Grievance Procedures

**Member Liability – Appeal Time Frame Table**

Medicare Member appeals have standard and expedited processes as shown below.

<table>
<thead>
<tr>
<th>Type of Appeal</th>
<th>Provider Timeline for Submission</th>
<th>Applies to</th>
<th>Appeal Review</th>
<th>Standard Turnaround Time</th>
<th>Expedited Turnaround Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Payment</td>
<td>60 calendar days from EOP</td>
<td>Denied payment for a service already received</td>
<td>Anthem Blue Cross MMP G&amp;A department</td>
<td>Within 60 calendar days</td>
<td>Not available</td>
</tr>
<tr>
<td>Service</td>
<td>60 calendar days from denial letter</td>
<td>Denied request for a health service not already received</td>
<td>Anthem Blue Cross MMP G&amp;A department</td>
<td>Within 30 calendar days</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Prescription drugs</td>
<td>60 calendar days from denial letter</td>
<td>Denied request for a prescription drug not already received</td>
<td>Anthem Blue Cross MMP G&amp;A department</td>
<td>Within 7 calendar days</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Discontinuation of SNF, HHA or CORF services</td>
<td>60 calendar days from denial letter</td>
<td>Discontinuation of SNF, HHA, and CORF services previously approved and no longer determined to be medically necessary (does not apply to preservice or benefit denials).</td>
<td>Appeals should be lodged as per the denial letter issued to the appropriate QIO within the applicable time frame. The QIO will provide an immediate review. If the time frame has been missed, the appeal can be lodged with the Anthem Blue Cross Cal MediConnect Plan G&amp;A department. Anthem Blue Cross Cal MediConnect Plan G&amp;A will review the request as expedited (within 72 hours).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

When a Medicare Member receives the “Important Message from Medicare” when being discharged from the hospital.
Provider Complaint and Grievance Procedures

Further Appeal Rights

If **Anthem Blue Cross** is unable to reverse the original denial decision in whole or part, the following additional steps will be taken:

- **Medicare Covered Services**
  - **Anthem Blue Cross** will forward the appeal to an Independent Review Entity (IRE) contracted with the federal government. The IRO will review the appeal and make a decision:
    - Within 72 hours if expedited
    - Within 30 days if the appeal is related to authorization for health care
    - Within 60 days if the appeal involves reimbursement for care
    - Prescription drug appeals are not forwarded to the IRO by **Anthem Blue Cross** but may be requested by the Member or representative; information will be provided on this process during the **Anthem Blue Cross** Medicare Member appeals process
  - If the IRE issues an adverse decision (not in the Member’s favor) and the amount at issue meets a specified dollar threshold, the Member may appeal to an Administrative Law Judge (ALJ)
  - If the Member is not satisfied with the ALJ’s decision, the Member may request review by the Medicare Appeals Council. If the Medicare Appeals Council refuses to hear the case or issues an adverse decision, the Member may be able to appeal to a federal court

- **Medicaid Covered Services**
  - Only covered under Medicaid (DHCS), including LTSS Services, covered non-Part D Drugs, Behavioral Health:
  - The appeal may be filed externally by the Member to the DHCS Appeals Division
  - A response will be issued within 72 hours for an expedited appeal
  - During the first year of the demonstration, a response will be issued within 90 calendar days (75 calendar days in year two, and 30 calendar days in subsequent years)

- **Medicare and Medicaid Covered Services**
  - Any appeals that overlap Medicare and Medicaid (including, but not limited to, home health, durable medical equipment and skilled therapies, but excluding Part D) will be auto-forwarded to the IRE. The Member may also submit a request to the DHCS Appeals Division. The outcome more favorable to the Member will be what **Anthem Blue Cross** is bound to.
Provider Complaint and Grievance Procedures

Member Grievance

A Member grievance is the type of complaint a Member makes regarding any other type of problem with Anthem Blue Cross or a Provider. For example, complaints concerning quality of care, waiting times for appointments or in the waiting room and the cleanliness of the Provider’s facilities are grievances.

Anthem Blue Cross must accept grievances from Members orally or in writing within 60 days of the event. Anthem Blue Cross must make a decision and respond to the grievance within 30 days. A Member can request an expedited grievance, in which case Anthem Blue Cross has 24 hours to respond. An expedited grievance can only be initiated if Anthem Blue Cross refuses to grant the Member an expedited organization/coverage determination or an expedited reconsideration/redetermination. Anthem Blue Cross can request up to 14 additional days to respond to a grievance with good reason. The 14 day extension does not apply to grievances related to Medicaid only services (LTSS Services, covered non-Part D drugs and Behavioral Health).

Anthem Blue Cross will display on its main page a link to the electronic grievance form located on the Medicare.Gov Internet Web site. Associates will also provide assistance in completing any forms, or other procedural steps, to support the Member filing the grievance.

Members may also file a grievance to the Center for Medicare and Medicaid Services (CMS) by dialing 1-800-MEDICARE, completing the electronic Grievance form on Medicare.Gov, [CMSgrievancecontact@CMS.Gov], or by mailing the grievance to:

Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Resolving Member Grievances

If a Member has a grievance about Anthem Blue Cross, a Provider or any other issue, Providers should instruct the Member to call Member Services at 1-855-817-5787 and TTY users should call 1-800-855-2880 during regular business hours or send a written grievance to:

Complaints, Appeals and Grievances Department
Anthem Blue Cross
P.O. Box 61116
Virginia Beach, VA 23466
Fax: 1-855-856-1724
Provider Complaint and Grievance Procedures

Billing Members / Cost Sharing

Providers may NOT collect any additional payment for cost-sharing obligations from California Cal MediConnect Program members other than those specified in a Member’s plan Summary of Benefits. In the MMP program, member cost sharing obligations are limited to “Patient Pay” amounts authorized by DHCS for some members for certain nursing home and long term services; and copayments for some prescription drugs covered under Medicare Part D.

Anthem Blue Cross will process provider claims in accordance with the California Cal MediConnect Program demonstration integrated Medicare/ Medicaid benefit package. Unless specifically noted as one of the exceptions above, Anthem Blue Cross payment is payment in full and Providers may not bill Members for cost sharing.

Provider Complaint and Grievance Procedures

Noncovered Services

Before rendering services, Providers should always inform Members of the cost of services not covered under the Anthem Blue Cross Cal MediConnect Plan that will be charged to the Member.

A Provider who chooses to provide services not covered under the Anthem Blue Cross Cal MediConnect Plan:

- Understands Anthem Blue Cross only reimburses for services that are medically necessary, including hospital admissions and other services
- Understands he or she may not bill for or take recourse against a Member for denied or reduced claims for services within the amount, duration and scope of benefits of the California Cal MediConnect Program.
- Obtains the Member’s signature on the Client Acknowledgment Statement, specifying the Member will be held responsible for payment of services prior to rendering services; alternatively, the Provider can follow the in-office denial process
- Members residing in SNFs can use their Share of Cost towards non covered services and this must be documented in the members medical record at the SNF. SNFs most follow the requirements for Billing as noted in Chapter 5.

Provider Complaint and Grievance Procedures

Client Acknowledgement Statement

A Provider may bill an Anthem Blue Cross Cal MediConnect Plan Member for a service that has been denied as not medically necessary or not a covered benefit only if both of the following conditions are met:
Chapter 14: PROVIDER COMPLAINT AND GRIEVANCE PROCEEDURES

Anthem Blue Cross Cal MediConnect Plan

- The Member requests the specific service or item
- The Provider obtains and keeps a written acknowledgement statement signed by the Member and the Provider stating:

I understand that, in the opinion of (Provider’s name), the services or items I have requested to be provided to me on (dates of service) may not be covered under Anthem Blue Cross as being reasonable and medically necessary for my care or are not a covered benefit. I understand Anthem Blue Cross has established the medical necessity standards for the services or items I request and receive. I also understand I am responsible for payment of the services or items I request and receive if these services or items are determined to be inconsistent with the Anthem Blue Cross medically necessary standards for my care or not a covered benefit.

Member Name: _____________________________ Member ID: ________________
Type of Service: _______________________________________________________
Cost of Service: $__________________
Member Signature: ________________________ Date: __________

IMPORTANT: Anthem Blue Cross Cal MediConnect Plan Members must NOT be balance billed for the difference between the amount paid by Anthem Blue Cross and the billed amount for covered services.

In addition, Providers may not bill a Member if any of the following occurs:
- Failure to submit a claim in a timely manner, including claims not received by Anthem Blue Cross
- Failure to submit a claim to Anthem Blue Cross for initial processing within the 365-day filing deadline
- Failure to submit a corrected claim within the 365-day filing resubmission period
- Failure to appeal a claim within the 60-day administrative appeal period
- Failure to appeal a utilization review determination within 30 days of notification of coverage denial
- Submission of an unsigned or otherwise incomplete claim
- Errors made in claims preparation, claims submission or the appeal process

Provider Complaint and Grievance Procedures
Self-Service Website and Provider Inquiry Line

The Anthem Blue Cross self-service website at www.anthem.com/CA provides a host of online resources, such as our Online Provider Inquiry Tool for real-time claim status, eligibility verification and precertification status. You can also submit a claim or precertification request, print referral forms or directories or obtain a Member roster. Detailed instructions for use of
the Online Provider Inquiry Tool can be found on our website.

Toll-Free Automated Provider Services at the Cal MediConnect Customer Care
To support our Providers and Members, we have established Cal MediConnect Customer Care to assist with questions and concerns about the Anthem Blue Cross Cal MediConnect Plan. Cal MediConnect Customer Care is comprised of Coordinated Care subject matter experts and specializes in first-call resolution for Provider and Member inquires. Our Cal MediConnect Customer Care representatives can help:

- Resolve payment disputes, appeals and other claims issues
- Verify claims status, Member eligibility, preauthorization requirements and the status of health care services
- Identify participating Anthem Blue Cross Cal MediConnect Plan Providers for referring Members to specialty services
- Support noncompliant Members (e.g., Members who repeatedly miss appointments, Members who are noncompliant with their treatment plans, etc.)

Cal MediConnect Customer Care is available Monday through Friday from 8 a.m. until 10 p.m. local time toll free at 1-855-817-5786. Information is available through the automated system, or you can be transferred to the appropriate department for other needs, such as seeking advice in case/care management.
CHAPTER 15: MEMBER RIGHTS AND RESPONSIBILITIES

Member Rights and Responsibilities

Overview

Providers are required to adhere to Centers for Medicare & Medicaid Services (CMS), DHCS, and Anthem Blue Cross requirements concerning issuing letters and notices.

Anthem Blue Cross Cal MediConnect Plan Members have the right to timely quality care and treatment with dignity and respect. Providers must respect the rights of all Anthem Blue Cross Cal MediConnect Plan Members.

Members have the right to:

A Member has the right to:

• Be treated with dignity and respect
• Be afforded privacy and confidentiality in all aspects of care and for all health care information, unless otherwise required by law
• Be provided a copy of his or her medical records, upon request, and to request corrections or amendments to these records
• Not to be discriminated against based on race, ethnicity, national origin, religion, sex, age, sexual orientation, medical or claim history, mental or physical disability, genetic information, or source of payment
• Have all plan options, rules, and benefits fully explained, including through use of a qualified interpreter if needed
• Access to an adequate network of primary and specialty providers who are capable of meeting the his or her needs with respect to physical access, and communication and scheduling needs, and are subject to ongoing assessment of clinical quality including required reporting
• Choose a plan and Provider at any time, including a plan outside of the demonstration, and have that choice be effective the first calendar day of the following month
• Have a voice in the governance and operation of the integrated system, Provider or health plan
• Ability to participate in all aspects of care and to exercise all rights of appeal
• Receive a Health Risk Assessment upon enrollment in a plan and to participate in the development and implementation of a Plan of Care. The assessment must include considerations of social, functional medical, behavioral, wellness and prevention domains, and evaluation of the member’s strengths and weaknesses, and a plan for managing and coordinating member’s care. Members, or their designated representatives, also have the right to request a reassessment by the interdisciplinary team, and be fully involved in any such reassessment.
• Receive complete and accurate information on his or her health and functional status by the interdisciplinary team
• Be provided information on all program services and health care options, including available treatment options and alternatives, presented in a culturally appropriate manner, taking in...
to consideration the member’s condition and ability to understand. A participant who is unable to participate fully in treatment decisions has the right to designate a representative. This includes the right to have translation services available to make information appropriately accessible. Information must be available:

- Before enrollment
- At enrollment
- At the time a participant’s needs necessitate the disclosure and delivery of such information in order to allow the participant to make an informed choice

- Be encouraged to involve caregivers or family members in treatment discussions and decisions
- Have advanced directives explained and to establish them, if the participant so desires
- Receive reasonable advance notice, in writing, of any transfer to another treatment setting and the justification for the transfer
- Be afforded the opportunity file an Appeal if services are denied that he or she thinks are medically indicated, and to be able to ultimately take that Appeal to an independent external system of review
- Receive medical and non-medical care from a team that meets the member’s needs, in a manner that is sensitive to the member’s language and culture, and in appropriate care setting, including the home and community
- Be free from any form or restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation
- Be free to exercise his or her rights and that the exercise of those rights does not adversely affect the way the health plan, Providers or the State agency treat the member
- Receive timely information about plan changes. This includes the right to request and obtain the information listed in the Orientation materials at least once per year, and the right to receive notices of any significant change in the information provided in the Orientation materials at least 30 days prior to the intended effective date of the change.
- Be protected from liability for payment of any fees that are the obligation of the health plan
- Not to be charged any cost sharing for Medicare Part A and B services

**Members have the responsibility to:**

- To be fully involved in maintaining his or her health and making decisions about their health care, including the right to refuse treatment if desired, and must be appropriately informed and supported to this end
- Provide to his or her health care Provider accurate and complete information about present complaints, past illnesses, hospitalizations, medications and other matters related to his or her health to the best of his or her knowledge
- Report unexpected changes in his or her condition to the health care Provider
- Report to the health care Provider whether he or she understands a suggested course of action and what is expected of him or her
- Follow the treatment plan recommended by his or her health care Provider
- Keep appointments and, when unable to do so for any reason, notify the health care Provider or health care facility
- Be responsible for his or her actions if refusing treatment or not following the health care Provider’s instructions
- Ensure the financial obligations of his or her health care are fulfilled as promptly as possible
- Follow health care facility rules and regulations affecting patient care and conduct
- Notify Anthem Blue Cross if they have questions, concerns, problems or suggestions (Members may call Member Services at 1-855-817-5785 and TTY users should call 1-800-855-2880)
CHAPTER 16: FRAUD AND ABUSE

Fraud and Abuse
General Obligations to Prevent, Detect and Deter Fraud, Waste and Abuse

As a recipient of funds from state and federally sponsored health care programs, Anthem Blue Cross has a duty to help prevent, detect and deter fraud, waste and abuse. Anthem Blue Cross is committed to detecting, mitigating and preventing fraud, waste and abuse as outlined in its Corporate Compliance Program. As part of the requirements of the federal Deficit Reduction Act, each Provider is required to adopt Anthem Blue Cross policies on detecting, preventing and mitigating fraud, waste and abuse in all the federally and state funded health care programs in which Anthem Blue Cross participates.

The Anthem Blue Cross policy on fraud, waste and abuse prevention and detection is part of the Anthem Blue Cross Compliance Program. Electronic copies of this policy and the Code of Business Conduct and Ethics can be found on the website at www.anthem.com/CA.

Anthem Blue Cross maintains several ways to report suspected fraud, waste and abuse. As a participant in government-sponsored health care, you and your staff are obligated to report suspected fraud, waste and abuse. These reports can be made anonymously www.anthem.com/CA. In addition to anonymous reporting, suspected fraud, waste and abuse may also be reported by calling Cal MediConnect Customer Care at 1-855-817-5786.

In order to meet the requirements under the Deficit Reduction Act, you must adopt the Anthem Blue Cross fraud, waste and abuse policies and distribute them to any staff Members or contractors who work with Anthem Blue Cross. If you have questions or would like more details concerning the Anthem Blue Cross fraud, waste and abuse detection, prevention and mitigation program, please contact the Anthem Blue Cross Chief Compliance Officer.

Fraud and Abuse
Importance of Detecting, Deterring and Preventing Fraud, Waste and Abuse

Health care fraud costs taxpayers increasingly more money every year. State and federal laws are designed to crack down on these crimes and impose strict penalties. Fraud, waste and abuse in the health care industry may be perpetuated by every party involved in the health care process. There are several stages to inhibiting fraudulent acts, including detection, prevention, investigation and reporting. In this section, Anthem Blue Cross educates Providers on how to help prevent Member and Provider fraud by identifying the different types as the first line of defense.

Many types of fraud, waste and abuse have been identified, including the following:

Provider Fraud, Waste and Abuse

- Billing for services not rendered
- Billing for services that were not medically necessary
Chapter 16: FRAUD AND ABUSE

Anthem Blue Cross
Anthem Blue Cross Cal MediConnect

- Double billing
- Unbundling
- Upcoding

Member Fraud, Waste and Abuse
- Benefit sharing
- Collusion
- Drug trafficking
- Forgery
- Illicit drug seeking
- Impersonation fraud
- Misinformation/misrepresentation
- Subrogation/third-party liability fraud
- Transportation fraud

Providers can prevent fraud, waste and abuse by ensuring the services rendered are medically necessary, accurately documented in the medical records and billed according to American Medical Association guidelines.

To help prevent fraud, waste and abuse, Providers can educate Members about these types of fraud and the penalties levied. Also, spending time with patients and reviewing their records for prescription administration will help minimize drug fraud and abuse. One of the most important steps to help prevent Member fraud is as simple as reviewing the Cal MediConnect Member ID card. It is the first line of defense against fraud. Anthem Blue Cross may not accept responsibility for the costs incurred by Providers rendering services to a patient who is not an Anthem Blue Cross Cal MediConnect Member, even if that patient presents a Member ID card. Providers should take measures to ensure the cardholder is the person named on the card.

Additionally, encourage Members to protect their cards as they would a credit card or cash, carry their Anthem Blue Cross Cal MediConnect Member ID card at all times, and report any lost or stolen cards to Anthem Blue Cross as soon as possible.

Anthem Blue Cross believes awareness and action are vital to keeping the state and federal programs safe and effective. Understanding the various opportunities for fraud, waste and abuse and working with Members to protect their Anthem Blue Cross Cal MediConnect ID card can help prevent fraud, waste and abuse. Anthem Blue Cross encourages its Members and Providers to report any suspected instance of fraud, waste and abuse using the contact methods referenced earlier. No individual who reports violations or suspected fraud, waste or abuse will be retaliated against, and Anthem Blue Cross will make every effort to maintain anonymity and confidentiality.
Fraud and Abuse

Health Insurance Portability and Accountability Act

The Health Insurance Portability and Accountability Act (HIPAA, also known as the Kennedy-Kassebaum Bill) was signed into law in August 1996. The legislation improves the portability and continuity of health benefits, ensures greater accountability in the area of health care fraud and simplifies the administration of health insurance.

Anthem Blue Cross strives to ensure both Anthem Blue Cross and contracted participating Providers conduct business in a manner that safeguards Patient/Member information in accordance with the privacy regulations enacted pursuant to HIPAA. Providers must have the following procedures in effect since April 14, 2003, to demonstrate compliance with the HIPAA privacy regulations.

Anthem Blue Cross recognizes its responsibility under the HIPAA privacy regulations to only request the minimum necessary Member information from Providers to accomplish the intended purpose. Conversely, Providers should only request the minimum necessary Member information required to accomplish the intended purpose when contacting Anthem Blue Cross. However, please note the privacy regulations allow the transfer or sharing of Member information, which may be requested by Anthem Blue Cross to conduct business and make decisions about care such as a Member’s medical record to make an authorization determination or resolve a payment appeal. Such requests are considered part of the HIPAA definition of treatment, payment or health care operations.

Fax machines used to transmit and receive medically sensitive information should be maintained in an environment with restricted access to individuals who need Member information to perform their jobs. When faxing information to Anthem Blue Cross, verify the receiving fax number is correct, notify the appropriate staff at Anthem Blue Cross and verify the fax was appropriately received.

Internet email (unless encrypted) should not be used to transfer files containing Member information to Anthem Blue Cross (e.g., Excel spreadsheets with claim information). Such information should be mailed or faxed.

Please use professional judgment when mailing medically sensitive information such as medical records. The information should be in a sealed envelope marked confidential and addressed to a specific individual, P.O. Box or department at Anthem Blue Cross.

The Anthem Blue Cross voicemail system is secure and password-protected. When leaving messages for Anthem Blue Cross associates, Providers should only leave the minimum amount
of Member information required to accomplish the intended purpose.

When contacting **Anthem Blue Cross**, Providers should be prepared to verify their name, address and Tax Identification Number or National Provider Identifier number.
CHAPTER 17: Glossary of Terms

AAPSF: Accreditation Association for Podiatric Surgical Facilities

AAAHC: Accreditation Association for Ambulatory Health Care

AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities

ABMS: American Board of Medical Specialties

ABCN: American Board of Clinical Neuropsychology

ABPN: American Board of Professional Neuropsychology

ACHC: Accreditation Commission for Health Care

AOA: American Osteopathic Association

APA: American Psychological Association

Appeal: Appeals are any of the procedures that deal with the review of adverse organization or coverage determinations on the health care services or prescription drug benefits a Member is entitled to receive or any amounts the Member must pay for a covered service. These procedures include reconsiderations by Anthem Blue Cross, the Part D Quality Improvement Council, hearings before an administrative law judge, reviews by the Medical Appeals Council and federal judicial reviews. This process is separate from the Provider administrative appeals/dispute process.

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

CACREP: Council for Accreditation of Counseling and Related Educational Programs

CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

Certification: Board Certification as recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the American Board of Orthopedic and Primary Podiatric Medicine, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery

CHAMPUS: The Civilian Health and Medical Program of the Uniformed Services (in the United States). CHAMPUS is a federally funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.
CHAP: Community Health Accreditation Program

CHEA: Council for Higher Education Accreditation, an agency recognized by the Company which publishes a reference used to verify the status of educational programs

CMS: Centers for Medicare & Medicaid Services; the federal agency under the Department of Health and Human Services responsible for administering the Medicare and Medicaid programs

COAMFTE: Committee on Accreditation for Marriage and Family Therapy Education

Company Credentials Committee (CC): A local credentialing and Peer Review body authorized to make decisions regarding the credentials of all practitioners and HDOs initially applying for and those requesting continued participation in the Anthem Blue Cross Cal MediConnect Plan Network

Company Medical Directors: Those Medical Directors with responsibility for the Medical Operations and Quality Management activities

Covered services: Those benefits, services or supplies that are:
- Provided or furnished by Providers or authorized by Anthem Blue Cross or its Providers
- Emergency services and urgently needed services that may be provided by non-Providers
- Renal dialysis services provided while Members are temporarily outside the service area
- Basic and supplemental benefits

Credentialing staff: Any associate in the Credentialing Department

CSWE: Council on Social Work Education

Emergency medical condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual in serious jeopardy, serious impairment to body functions, or serious dysfunction of any bodily organ or part.

Emergency services: Covered Inpatient and outpatient services that are furnished by a Provider qualified to furnish such services and that are needed to evaluate or stabilize an Enrollee’s Emergency Medical Condition.

Experimental procedures and items: Procedures and items determined by Anthem Blue Cross and Medicare not to be generally accepted by the medical community. When making a determination as to whether a service or item is experimental, Anthem Blue Cross will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or CMS guidance already made by Medicare and Medicaid.
Chapter 17: Glossary of Terms

Exceptions: An exception request is a type of coverage determination request. Through the exception process, the Member can request an off-formulary drug, an exception to the Anthem Blue Cross tiered cost-sharing structure or an exception to the application of a cost utilization management tool (e.g., step therapy requirement, dose restriction or precertification requirement).

Fee-for-service Medicare: A payment system by which doctors, hospitals and other Providers

Formal Appeal: The process by which Anthem Blue Cross’s adverse credentialing decision is challenged

Grievance: A complaint or dispute other than one involving an organization determination. Examples of issues involving a complaint that is resolved through the grievance rather than the appeal process are waiting times in physician offices and rudeness or unresponsiveness of customer service staff.

Healthcare Integrity and Protection Data Bank (HIPDB): The national databank maintained by the U.S. Department of Health and Human Services or its designated contractor, created pursuant to the Health Insurance Portability and Accountability Act (HIPAA) to combat fraud and abuse in the health insurance and health care delivery system.

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

HFAP: Healthcare Facilities Accreditation Program (a program of the American Osteopathic Association formerly referred to as AOACHA - American Osteopathic Association Committee on Hospital Accreditation)

Home health agency: A Medicare-certified home health agency is one that provides intermittent skilled nursing care and other therapeutic services in a Member’s home when medically necessary, when Members are confined to their home and when authorized by their primary care physician.

Hospice: A Medicare-certified organization or agency primarily engaged in providing pain relief, symptom management and support services to terminally ill people and their families.

Hospital: A Medicare-certified institution licensed by the state that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term hospital does not include a convalescent nursing home, rest facility or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

Immediate Termination: A termination of network participation which is effective immediately. It occurs prior to review by the committee and prior to the Provider/HDO being allowed an
appeal. It is used when determined necessary by Anthem Blue Cross to protect against imminent danger to the health or welfare of its Members.

IMQ: Institute for Medical Quality

Independent practice association: A group of physicians that function as a contracting medical Provider/group but in which the individual Member physicians operate their respective independent medical offices

Informal Review/Reconsideration: A process through which a practitioner or HDO is given the opportunity to submit additional information to Anthem Blue Cross for its consideration. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the Informal Review/Reconsideration, Anthem Blue Cross at its discretion, may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Anthem Blue Cross representative telephonically. In any event, an Informal Review/Reconsideration shall not include privileges equal to or greater than those offered in a Formal Appeal.

Initial Applicant: Any person or organization that provides health care services which has applied for participation with Anthem Blue Cross and Blue Shield or Anthem Blue Cross to provide health care services to Anthem Blue Cross Cal MediConnect Plan Members.

Medicaid: The federal health insurance program established by Title XIX of the Social Security Act and administered by states for low-income individuals

Medically Necessary: Per Medicare, services must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, or otherwise medically necessary under 42 U.S.C. 1395y.

We make determinations of medical necessity based on peer-reviewed medical literature, publications, reports and evaluations; regulations and other types of policies issued by federal government agencies, Medicare local carriers and intermediaries; and such other authoritative medical sources as deemed necessary by Anthem Blue Cross

Medicare: The federal health insurance program established by Title XVIII of the Social Security Act and administered by the federal government for elderly and disabled individuals

Member: A Medicare and Medicaid beneficiary entitled to receive covered services, who are enrolled in the Anthem Blue Cross Cal MediConnect Plan and whose enrollment has been confirmed by CMS.

National Credentials Committee: A committee composed of Anthem Blue Cross’s Medical Directors, Medical Director of Medical Policy and Credentialing and chaired by the VP Medical Policy, Technology Assessment & Credentialing. It is responsible for the development and maintenance of a consistent National Credentialing Policy. This committee shall establish policy
governing all aspects of credentialing of network practitioners and HDOs, including but not limited to scope, criteria, confidentiality, delegation and appeals.

**National Credentialing Policy:** Policy defined by National Credentials Committee and set forth in this document

**NIAHO:** National Integrated Accreditation for Healthcare Organizations

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

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

**Participating Provider:** Any person or organization, including practitioners and facilities, that provides health care services and has entered into an agreement with Anthem Blue Cross or Anthem Blue Cross and Blue Shield to provide health care services to Anthem Blue Cross Cal MediConnect Plan Members

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

**Practitioner:** An individual person who is licensed in accordance with all applicable state and federal laws to deliver health care services

**Primary Care Providers and/or Primary Care Physicians (PCPs):** Physicians who elect and are selected as PCPs and who practice in the following specialties: pediatrics, internal medicine, family practice, geriatricians, general practice

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

**Provider:** Any professional person, organization, health facility, hospital, or other person or institution licensed and/or certified by the state and/or Medicare to deliver or furnish health care services. This individual or organization has a contract directly or indirectly with Anthem Blue Cross to provide services directly or indirectly to Medicare Members pursuant to the terms of the participating Provider Agreement.
Provider liability appeal: A request for Anthem Blue Cross to review a decision by the Anthem Blue Cross Health Care Management department for services already rendered and denied without Medicare Member liability.

Provider payment dispute: A request for Anthem Blue Cross to review the claim adjudication as the Provider feels payment was not rendered as per the contractual agreement between Anthem Blue Cross and the Provider.

Service area: A geographic area approved by CMS within which an eligible individual may enroll in a Medicare Advantage plan. The geographic area for the Anthem Blue Cross is located in the Summary of Benefits document.

Share of Cost / Member Liability - When an Enrollee’s income exceeds an allowable amount; he or she must contribute toward the cost of their LTC services. This contribution, known as the Share of Cost amount, is required for Enrollees residing in a NF and for those receiving other waiver services. Patient Pay is required to be calculated for every Enrollee receiving NF or waiver services, although not every eligible Enrollee will end up having to pay each month.

Specialty: Those fields of clinical practice recognized by Anthem Blue Cross’ Credentialing Program.

TJC: The Joint Commission.

Urgently needed services: Those covered services provided when the Member is temporarily absent from the Medicare Advantage service area or under unusual and extraordinary circumstances, services provided when the Member is in the service area but the Member’s PCP is temporarily unavailable or inaccessible, when such services are medically necessary and immediately required as a result of an unforeseen illness, injury or condition; and it is not reasonable given the circumstances to obtain the services through the PCP.
Cal MediConnect health plan coverage is offered through a contract with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Enrollment in Anthem Blue Cross depends on contract renewal. Anthem Blue Cross is a health plan that contracts with both Medicare and Medi-Cal to provide benefits of both programs to enrollees. Anthem Blue Cross is the trade name of Blue Cross of California and Anthem Blue Cross Partnership Plan is the trade name of Blue Cross of California Partnership Plan, Inc. 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.