Chapter Contents

*(Click on “Bookmarks” at left of screen for links to each chapter)*

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Inquiries</td>
</tr>
<tr>
<td>2</td>
<td>BlueCare Health Plan</td>
</tr>
<tr>
<td>3</td>
<td>New England Health Plans</td>
</tr>
<tr>
<td>4</td>
<td>Century Preferred</td>
</tr>
<tr>
<td>5</td>
<td>State Preferred</td>
</tr>
<tr>
<td>6</td>
<td>Comprehensive &amp; Indemnity Plans</td>
</tr>
<tr>
<td>7</td>
<td>Federal Employee Program (FEP)</td>
</tr>
<tr>
<td>8</td>
<td>Medigap Programs</td>
</tr>
<tr>
<td>9</td>
<td>National Accounts</td>
</tr>
<tr>
<td>10</td>
<td>BlueCard</td>
</tr>
<tr>
<td>11</td>
<td>Utilization Management</td>
</tr>
<tr>
<td>12</td>
<td>Quality Management</td>
</tr>
<tr>
<td>13</td>
<td>Institutional Programs</td>
</tr>
<tr>
<td>14</td>
<td>Prescription Drug Programs</td>
</tr>
<tr>
<td>15</td>
<td>Coordination of Benefits</td>
</tr>
<tr>
<td>16</td>
<td>Claims</td>
</tr>
<tr>
<td>17</td>
<td>Compensation</td>
</tr>
<tr>
<td>18</td>
<td>Physician/Provider Participation Requirements</td>
</tr>
<tr>
<td>19</td>
<td>Appeals</td>
</tr>
<tr>
<td>20</td>
<td>Forms</td>
</tr>
<tr>
<td>21</td>
<td>Correspondence</td>
</tr>
<tr>
<td>22</td>
<td>Glossary</td>
</tr>
<tr>
<td>23</td>
<td>Appendix</td>
</tr>
</tbody>
</table>
1. INQUIRIES

See individual manual chapters for additional contacts

Claims/Membership Inquiries

Provider Call Center
Representatives in our Provider Call Center are available to answer questions about policies, claims and compensation.

For assistance, call (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven) Monday through Friday, 8:15 a.m. to 5 p.m.

Electronic Claim Submission Inquiries

For inquiries regarding electronic claims submission call the EDI Unit at:

(800) 334-8262 (toll free in Conn.)

Anthem Online Provider Services (AOPS)

Anthem.com ➔ select Providers ➔ select Connecticut ➔ click on Anthem Online Provider Services

Anthem Online Provider Services (AOPS), is our secure Internet site specifically developed for our participating providers. It is available nearly 24/7 at no charge and offers a wealth of information, including coverage and claim status information.

Register for AOPS
Participation requires completion of a signed User Agreement, which is available on the AOPS Provider Home Page by clicking on Sign Up Now, or you can contact the Provider Call Center at (800) 922-3242 or (203) 239-3884 and ask to speak with your Provider Representative.
2. BLUECARE HEALTH PLAN HMO

NOTE:
- *State Preferred* and *New England Health Plans* are covered in separate sections of this manual.
- The *BlueCare Family Plan* is not covered in this manual.

Table of Contents

Key Telephone Numbers........................................................................................................................ 2

Program Overview.................................................................................................................................. 2
Identification Card................................................................................................................................. 3

Utilization Management Procedures .................................................................................................... 4
  Office Visit Procedures ..................................................................................................................... 4
  Referrals........................................................................................................................................ 5
  Prior Authorization of Inpatient and Outpatient Services................................................................. 6
  Obstetrician/Gynecologist ................................................................................................................ 6
  Notification of Maternity Admissions ............................................................................................... 6
  Preventive and Well Care Schedule .................................................................................................... 6
  Behavioral Health Treatment ............................................................................................................. 7
  Physical and Occupational Therapy .................................................................................................. 7
  Chiropractic.................................................................................................................................... 7
  Durable Medical Equipment (DME) ..................................................................................................... 7
  Prosthetic Equipment......................................................................................................................... 8
  Vision Care..................................................................................................................................... 9
  Expedited Review Hotline - Inpatient Care ......................................................................................... 9
  Urgent Care..................................................................................................................................... 9
  Emergency Admissions Authorization ............................................................................................... 9

Laboratory............................................................................................................................................. 11
  Laboratory Services Eligible for Coverage when Performed in the Physician’s Office ................ 11

Benefit Programs ................................................................................................................................ 11
  Standard *BlueCare Health Plan* Programs ..................................................................................... 11
  State *BlueCare POE, Plus POE and POS* ......................................................................................... 13
  *BlueCare Basic and BlueCare Plus Basic* ....................................................................................... 13
  *BlueCare Direct and BlueCare Plus Direct* ..................................................................................... 13
  Non-Standard *BlueCare Health Plan Programs* ............................................................................. 13
Key Telephone Numbers

Claim, Benefit and Membership Inquiries
(Provider Call Center)
(800) 922-3242 (toll free in Conn.)
or (203) 239-3884 (local North Haven)

Laboratory
(800)CCL-SITE (225-7483)

Utilization Management

Behavioral Health
(800) 934-0331 (toll-free, 24-hrs)

Case Management
(800) 231-8254

Clinical Transition
(203) 239-8649

Emergency Admissions
(800) 238-2227 (toll free)

Notification and Urgent Care

Expedited Review Hotline
(888) 507-8803, or, if busy, (888) 506-2272

Prior Authorization, inpatient:
- Inpatient Admissions
- Transplants
- Maternity (Notification only) fax (203) 985-7388

Prior Authorization, outpatient
- Anthem Behavioral Health
  (800) 934-0331 (24-hours)
- DME
  (800) 922-3242
- Diagnostic Radiology Services (NIA)
  (888) 864-7237
- Specified Outpatient Surgeries
  (800) 238-2227 (toll free)

BLUECARE HEALTH PLAN*
Program Overview

*NOTES:
- State Preferred and New England Health Plans are covered in separate sections of this manual.
- The BlueCare Family Plan is not covered in this manual.
Non-Standard Plans:
In addition to the BlueCare Health Plan programs outlined above, Anthem provides the option of non-standard benefit programs to large employer groups. If you have any questions regarding a member’s coverage in a non-standard program, please contact the Provider Call Center.

Non-standard Coverage - “Carve-outs”
Employer groups covered by any of our products or programs may opt to “carve-out” specific portions of that coverage. Under these circumstances, the following could occur:
- Specific benefit(s) may not be covered that are covered under the standard plan.
- A specific area of coverage (e.g., behavioral health) may be provided by a vendor’s network of providers instead of the standard BlueCare Health Plan network.
- Information on carve-outs from standard plans may be printed on the member’s ID card. For further information on specific employee group coverage, contact the Provider Call Center.

Please see Appendix B for our HMO Member Bill of Rights and the Blue Cross Blue Shield Association Quality Commitments to Managed Care Members

Identification Card

1. **Member Name:** The full name of the cardholder.
   **Identification Number:** The 13-digit number used to identify each Anthem member. This number will include a 3-digit numerical prefix.

2. **Health Plan:** The name of the health plan and the type of coverage with copay amount(s).
   **Pharmacy:** The type of prescription drug coverage; lists copay amounts.
   **Dental:** The type of dental coverage.

3. **PCP Name:** Name of the member’s designated PCP.
   **Group Identification Number:** The 9-digit number used to identify the member’s employer.

**Blue Cross Blue Shield Plan Codes**
The numbers used to identify the codes assigned to each plan by the Blue Cross Blue Shield Association; used for claims submission when medical services are rendered out-of-state.

The State of Connecticut logo will be found on the upper right corner of the State BlueCare POS, State BlueCare Plus POE, and State BlueCare POE ID cards.

The suitcase logo indicates that the plan is a BlueCard POS or HMO product.

Always remember to check the back of the ID card for important information.
Utilization Management Procedures

- PCP selection and referrals* are required for BlueCare Plus, BlueCare Plus POS, BlueCare Plus NSB, BlueCare Plus Basic, BlueCare Plus Direct, BlueCare Plus Premier, BlueCare Plus Access 10 and State BlueCare Plus POE programs.

- PCP selection is not required, but is recommended, and referrals are not required for the BlueCare, BlueCare POS, State BlueCare POS or State BlueCare POE programs.

*Note: in 2004, Anthem began to transition groups out of our BlueCare Health Plan HMO and POS “Plus” plans, that require members to obtain referrals for specialty care from their Primary Care Physicians (PCPs). However, while these plans are no longer being offered to employer groups, there are still groups who still are covered under the “Plus” products which require referrals.

Office Visit Procedures
Following these steps will help ensure quick payment turnaround and help members minimize out-of-pocket costs.

NOTE: Please notify Provider Relations of any changes in your practice (change of address, change in Tax ID number, etc.). A change of address form is located in the Forms chapter of this manual.

Primary Care Physician
(Specialists, see page 2-6)

1) Review member’s ID card or enrollment form for accuracy.
2) Verify eligibility by calling (800) 922-3242.
3) Collect copay as listed on card.
4) Copy signed ID card front and back, or obtain signed release of information to the insurance affiliate.
5) Review PCP name and phone number on card.
6) Provide services or care required.
7) Determine whether a referral to a specialist is necessary:
   - BlueCare, BlueCare POS, BlueCare Basic, BlueCare Direct and State BlueCare POS (non-“Plus”) programs: No PCP referral is required for members to access specialty care. POS members who self-refer to a non-participating provider will be subject to deductibles, coinsurance and balance billing. BlueCare, BlueCare Basic, BlueCare Direct and State BlueCare POE members must access participating BlueCare Health Plan providers, since no out-of-network benefits apply.
   - All Other BlueCare Health Plan Programs: Members must obtain a referral from their PCP for specialty care. The PCP may refer to any participating provider. To refer a member to a non-participating specialty physician or health care provider, the PCP must obtain prior written authorization by contacting the Case Management Department at (800) 238-2227 (toll-free).

BlueCare Plus POS members may self-refer to participating and non-participating providers. However, they will be subject to deductibles and coinsurance, and to balance billing when care is rendered by a non-participating provider.

8) Submit CMS(HCFA)-1500 Form for payment or file the claim electronically according to the claims filing procedures outlined in the Claims chapter of this manual.

Anthem Blue Cross and Blue Shield Policies & Procedures Manual 2005 Rev.
IMPORTANT NOTES:

- **Participating providers must refer members to other participating providers.** If this requirement is not followed, Anthem may deny payment, and the member will be held harmless.

- **Participating providers may not balance bill a member when the claim is denied because of lack of medical necessity.** Neither Anthem nor the member is responsible for care that is determined to be medically unnecessary. The member may only be balance billed for these services if the provider secures the member’s consent to the care in advance of receiving it, and documents that consent, including the disclosure that the care will not be covered under the member’s health plan.

- **Members may not be held financially responsible for any amounts in excess of the contracted rate (i.e. balance billed for the amount between the contracted rate and the provider’s charge).**

**Referrals**

Note: in 2004, Anthem began to transition groups out of our BlueCare Health Plan HMO and POS “Plus” plans, that require members to obtain referrals for specialty care from their Primary Care Physicians (PCPs). However, while these plans are no longer being offered to employer groups, there are still groups who still are covered under the “Plus” products which require referrals.

**No referral is required to access specialty care for members of the following programs:**

- BlueCare
- BlueCare Basic
- BlueCare Direct
- BlueCare POS
- State BlueCare POS
- State BlueCare POE

Specialists, simply follow PCP office procedure steps #1-8 above.

**A referral is required to access specialty care for members of the following programs:**

- BlueCare Plus
- BlueCare Plus POS
- BlueCare Plus NSB
- BlueCare Plus Access 10
- BlueCare Plus Basic
- BlueCare Plus Direct
- BlueCare Plus Premier
- State BlueCare Plus POE

**Referring PCP**

The referral process is paper-less! If you are referring a member for specialty care:

1) **Make a note in the member’s record** and in your referral log, noting the member’s name, the date of the referral, and the specialist to whom the member is being referred.

2) **Contact the office of the specialty provider** to whom you are referring the patient to advise that provider of the member’s name and diagnosis.

   **Important! Be sure to give them your UPIN or referral authorization number.**

3) The specialty physician or health care provider is instructed to include the referring PCP’s name and UPIN number on the claim, which will act as authorization for the referral when he or she is filing a claim for services rendered to the PCP’s member/patient.

**Specialists**

If a member is referred to you:

1) **Follow basic office procedure** (see #1 - 6 under Primary Care Physician on page 2-4) **Make a note on the member’s record** or in your referral log, noting the member’s name, the date of referral and the UPIN number of the referring physician.

   - **Use of a PCP’s UPIN without a referral and consent from the PCP is strictly prohibited.**
2) **Indicate the referring PCP’s name** in Box 17 of the CMS(HCFA)-1500 claim form, and his or her UPIN number in Box 17a of the same form or the appropriate areas when filing electronically. **No separate referral form is required**, and benefits will be determined based on the information listed in these fields.

3) **You must report back to the referring PCP:**
   - after the first consultation to discuss the diagnosis and proposed treatment,
   - periodically during the course of treatment, and
   - at the time specialty treatment is discontinued.

4) If a member of one of the BlueCare Health Plan “Plus” products, which requires a PCP referral comes to you for specialty care without a referral, have them sign the “Member Self-Referral Acknowledgment” form found in the *Forms* section of this manual, and retain the form in the patient’s file.

For further information on specialty referrals see the *Utilization Management* section of this manual.

**Prior Authorization of Inpatient and Outpatient Services**

Prior authorization is required for a variety of services for BlueCare Health Plan members. Prior authorization phone numbers are listed in the *Key Telephone Numbers* section at the front of this chapter. Additional information can be found in the “Prior Authorization” section of the *Utilization Management* chapter.

**Obstetrician/Gynecologist**

(Maternity: Please see the *Utilization Management* chapter for maternity care information. See below for maternity admissions notification.)

1) **A female member may self-refer** to a participating Obstetrician/Gynecologist (OB/GYN) for any covered OB/GYN exam, care related to pregnancy, and covered primary or preventive OB/GYN services required as a result of a gynecological condition or exam. For BlueCare Health Plan “Plus” products, a referral is required for all other services performed by an Obstetrician/Gynecologist, including infertility treatments.

2) **BlueCare POS, BlueCare Plus POS, State BlueCare POS only:** Members may go out of network for care, however, services will be subject to coinsurance and deductibles and to balance billing when care is rendered by a non-participating provider.

   *BlueCare, BlueCare Basic, BlueCare Direct, BlueCare Plus NSB, BlueCare Plus Access 10, BlueCare Plus Direct, BlueCare Plus Basic, BlueCare Plus Premier and State BlueCare POE and Plus POE:* No out-of-network benefits are available unless prior authorized.

3) Obstetricians/Gynecologists may refer any member for treatment of breast mass, abnormal mammogram, pelvic mass, acute surgical emergency and all specialty services for pregnancy.

**Notification of Maternity Admissions**

Please see the “Maternity Admission Notification” section of the *Utilization Management* chapter of this manual for maternity notification information for BlueCare Health Plan members.

**Preventive and Well Care Schedule**

<table>
<thead>
<tr>
<th>Pediatric</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth - 1 year - 6 exams</td>
<td>22-29 years - 1 exam / 5 years</td>
</tr>
<tr>
<td>1-5 years - 6 exams</td>
<td>30-39 years - 1 exam / 3 years</td>
</tr>
<tr>
<td>6-10 years - 1 exam / 2 years</td>
<td>40-49 years - 1 exam / 2 years</td>
</tr>
<tr>
<td>11-21 year - 1 exam per year</td>
<td>50 years + - 1 exam per year</td>
</tr>
</tbody>
</table>
Vision Exam
Covered once every 24 months.

Hearing
Screening part of preventive exam

Routine Gynecological
Covered once every year.

Mammography
35-39 yrs (inclusive)- One baseline screening
40 and older - One per year.
Additional exams when medically necessary

Behavioral Health Treatment
No referral is required for BlueCare Health Plan members to access behavioral health services. However, if you wish to refer BlueCare Health Plan members for emergent or non-urgent behavioral health services, you may call (800) 934-0331 (toll free, 24 hours a day). Prior authorization of inpatient and partial hospital services must be obtained prior to treatment.

For specific behavioral health benefit information, please see the benefit matrices at the end of this section.

Physical and Occupational Therapy
For Physical and Occupational Therapy guidelines and requirements, please see the “Prior Authorization” section in the Utilization Management section of this manual.

Chiropractic
There are no prior authorization requirements for Chiropractic care for BlueCare Health Plan members. However, there are specific guidelines to follow to determine coverage and eligibility.

Please see the Utilization Management chapter of this manual for further information.

Durable Medical Equipment (DME)
Coverage limited to:
- Apnea monitors
- Glucometers (purchase only), or other approved home blood glucose testing equipment
- Pulmoaides (purchase only), or other approved nebulizer
- C-PAP
- Asthma Kit - including, but not limited to, portable peak flow meter, instructional video, brochure and spacer (optional)
- Wigs following chemotherapy (benefit maximum applies)

Member policy may include a DME Rider. Specifics on the DME Rider can be found below.

DME Prior Authorization
Call the Provider Call Center at (800) 922-3242 to determine if the DME request is eligible for coverage, and if prior authorization is required.

Durable Medical Equipment (DME) RIDER
The Durable Medical Equipment and Prosthetic Devices Rider provides added coverage for the member. It covers equipment for the diagnosis and treatment of illness and injury, which improves the functions of a body part or prevents the deterioration of a medical condition. Cost shares vary.
Durable medical equipment, prosthetic devices and orthotic appliances must be ordered by the member’s PCP or participating specialist, approved in advance by Anthem, and purchased at one of our approved suppliers (for a list of approved suppliers, see the HMO provider directory). Adjustments and replacements to prosthetics and orthotics are eligible for coverage with plan approval when necessary because of normal wear and tear, or body growth or change.

**Exclusions and Limitations:** Non-covered items include, but are not limited to, the following:
- Hearing Aids
- Home convenience items
- Exercise equipment
- Non-rigid appliances such as elastic stockings, ace bandages and splints
- Orthotics, orthopedic or corrective shoes (except for molded foot orthotics)
- Ambulatory blood pressure monitoring equipment
- Home uterine monitoring equipment
- Basic first aid supplies

**Prosthetic Equipment**
(If coverage includes DME Rider, the rider supersedes the standard benefit.)

**In-Network:** $1,000 limit per member per calendar year with 20% coinsurance. Prosthetic devices, whether surgically implanted or worn as an anatomic supplement, are eligible for coverage when prescribed by the PCP (some exclusions apply, see below) under the following conditions:

a) Repair, replacement, fitting and adjustments when made necessary by normal wear and tear or by body growth or change. Repair and replacement made necessary because of loss or damage caused by misuse or mistreatment are not eligible for coverage.

b) In cases of tumor of the oral cavity, non-dental prosthetic devices, including maxillo-facial prosthetic devices used to replace anatomic structures removed during treatment of head or neck tumors, and additional appliances essential for the support of such prosthetic devices.

c) The benefit for prosthetic devices following surgical removal of the breasts due to tumors is $300 per calendar year for each breast removed. The $300 per calendar year benefit is counted against the maximum benefit for prosthetic devices. If the maximum benefit for prosthetic devices has been met for other than the surgical removal of the breast due to tumors, the member is still guaranteed $300 per calendar year for each breast removed.

d) Benefits for services eligible for coverage for the medically necessary removal of any breast implant without regard to the reason for implantation is a maximum benefit of $1,000 per member per calendar year.

e) Prosthetic benefits now include:
   - Boston braces, Charleston bending braces and braces attached to orthopedic or corrective shoes.
   - Molded foot orthotics, abduction and rotation bars for the following diagnoses:
     Heel Spur, Fasciitis, Bursitis, Morton’s Neuroma, Posterial Tibial Dysfunction, Neurovascular Ulcer.

**Exclusions:** The following prosthetic devices are not eligible for coverage:
- Bite plates/dental plates
- Optical or visual aids, including eyeglasses or contact lenses, except for the treatment of congenital aphakia or for aphakia following cataract surgery when an intraocular lens is not medically possible
- Penile implants
- Xomed audiant bone conductors
- Arch supports and corrective shoes
- Experimental or research prostheses
Vision Care

Under all Commercial HMO programs, eye care services are eligible for coverage when performed by a participating BlueCare Health Plan provider. Consult the member's specific plan at the end of this section to determine if a member is eligible for out-of-network benefits and their specific vision benefits (i.e. vision exam coverage, copays and referrals).

- Referrals and prior authorization are not required for routine eye exams.
- Prior authorization may be required for some services that are surgical in nature. For prior authorization, call (800) 238-2227.
- Vision wear, contact lenses and laser vision correction discounts: Members can purchase contact lenses, high quality, brand-name vision wear, or obtain laser vision correction at discounted prices through our SpecialOffers@Anthem value-added discount program.

Vision Care Rider

Some BlueCare Health Plan members may have a vision rider in addition to their basic vision coverage which provides a flat dollar amount towards the items listed below:

- One complete eye exam (with or without cycloplegia) per member per year.
- One frame per member per year.
- One pair prescription lenses per member per year, as follows:
  a) Single vision, bifocal or trifocal lenses - made of plain glass, tinted (sun) glass, or industrial safety glass. Note: Progressive lenses are considered trifocal.
  b) Contact lenses (including fitting, training and lifetime warranty) when used to correct visual acuity to 20/70, or when medically necessary as determined by Anthem.

Contact lenses (including fitting, training and lifetime warranty) when used for any other reason are paid as single vision lenses.

Expedited Review Hotline - Inpatient Care

Participating providers have access to an “expedited review hotline” designed for emergent/life threatening situations. If a member has been admitted to a hospital, and the physician feels that the member’s life would be in danger or illness could occur if they are discharged or treatment is delayed, the physician may contact Utilization Management and request an expedited review.

A UM nurse is on call from 8 a.m. through 9 p.m., seven days a week to handle these requests. If the physician does not receive a response from Utilization Management within three hours from the time the call is made, the admission/extension is considered approved.

For expedited review, call toll free (888) 507-8803, or, if busy, (888) 506-2272.

Urgent Care

A comprehensive hospital-based urgent care network provides members access to urgent care 24 hours a day, seven days a week. Please refer to the most recent HMO Participating Provider Directory on anthem.com for a listing of participating hospital-based urgent care facilities.

Please see the “Urgent Care” section of the Utilization Management chapter of this manual for urgent care procedures and criteria.

Emergency Admissions Authorization

- Benefits for emergency care are provided for treatment of the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is needed.
In an emergency situation, members are directed to go immediately to the nearest emergency room and to contact their PCP as soon as possible.

Emergency admissions must be reported to the Utilization Management Department within 48 hours at (800) 238-2227.

Members are generally responsible for an emergency room copay for each visit that does not result in the patient being admitted as an inpatient directly from the emergency room. (Refer to the benefit matrices at the end of this section for specific copay information.)

**Emergency Treatment from a Non-Participating Provider:**

1) If a member requires emergency care from a non-participating provider, no prior authorization from the plan or the primary care physician is required.

2) The member must contact their PCP to arrange any medically necessary follow-up care as soon as he or she is able.

3) **If the member is admitted:** The member or admitting physician must report all inpatient admissions to the Utilization Management Department within 48 hours of admission by calling at (800) 238-2227 (inside CT) or (800) 248-2227 (out of state), or the number on the back of the member’s ID card.

4) **If the member is not admitted:** The member’s PCP must contact the Prior Authorization Department at (800) 742-3696.

**Laboratory**

Under all BlueCare Health Plan programs, diagnostic lab services are eligible for coverage in-network. All outpatient clinical laboratory and pathology services for BlueCare Health Plan are provided by Quest Diagnostic, Clinical Laboratory Partners LLC or a consortium of more than 30 participating hospital-affiliated laboratories or pathology groups. Under this arrangement, participating physicians and health care professionals are required to refer BlueCare Health Plan members, or send their specimens to one of these designated laboratories for service.

For Quest Diagnostics lab sites call: (800) 225-7483.

**Important Notes:**

- The following services are eligible for coverage when performed in the physician’s office.
- To improve the timeliness of claims, always include the diagnosis on your lab referral form.
- Quest Diagnostics can arrange services for lab work that requires special handling such as STAT or child proficient services. Please call them for further information.

**Laboratory Services Eligible for Coverage when Performed in the Physician’s Office**

(1/1/2001)

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81000</td>
<td>Urinalysis, by dip stick or tablet reagent; non-automated, with microscopy</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, non-automated, without microscopy</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, automated without microscopy</td>
</tr>
<tr>
<td>81005</td>
<td>Urinalysis, qualitative or semi-quantitative, except immunoassay</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis; bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81025</td>
<td>Urine preg test, by visual color comparison methods</td>
</tr>
<tr>
<td>82120</td>
<td>Amines, vaginal fluid, qualitative</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (eg, guaiac); feces, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>82803</td>
<td>Gasses, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation)</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose, quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose, blood, reagent strip</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycated</td>
</tr>
<tr>
<td>83986</td>
<td>PH, body fluid, except blood</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding Time</td>
</tr>
<tr>
<td>85007</td>
<td>Blood Count; manual differential WBC count (includes RBC morphology and platelet estimation)</td>
</tr>
<tr>
<td>85013</td>
<td>Hematocrit, spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit, other than spun hematocrit</td>
</tr>
</tbody>
</table>

 services approved for Pulmonologists ONLY
Benefit Programs

BlueCare Health Plan offers employers four standard types of health care programs. In addition to these standard programs, other BlueCare programs include:

- BlueCare Basic
- BlueCare Plus Basic*
- BlueCare Direct
- BlueCare Plus Direct*
- BlueCare Plus Premier*
- BlueCare Plus Access 10*
- BlueCare Plus NSB*
- State BlueCare POS
- State BlueCare POE
- State BlueCare Plus POE*

* Anthem Blue is currently transitioning groups out of our BlueCare Health Plan HMO and POS “Plus” plans, that require members to obtain referrals for specialty care from their Primary Care Physicians (PCPs). While the “Plus” plans are no longer being offered to employer groups, there are still groups who still are covered under the “Plus” products which require referrals.)

To determine a member’s type of coverage, simply check their ID card for the health plan name.

Standard BlueCare Health Plan Programs

- BlueCare Plus - A gatekeeper program which requires that members obtain all care from their primary care physician (PCP) or from a participating specialist. PCP referrals are required. All care must be received from participating BlueCare Health Plan providers. No out-of-network benefits are available. As of Jan. 1, 2005, this option is no longer available for new sales. Beginning with 2004 renewals, members will be migrating from gatekeeper programs (BlueCare Plus and BlueCare Plus POS) to comparable non-gatekeeper programs (BlueCare and BlueCare POS).
- **BlueCare** - Provides benefits when care is provided only by participating physicians and other health care professionals. However, as this is a non-gatekeeper program, PCP referrals are not required.

- **BlueCare Plus POS** - A gatekeeper program which provides benefits for both in-network and out-of-network services. However, members can maximize their coverage and reduce out-of-pocket expenses by obtaining referrals from their PCP and from receiving care from participating physicians. As of Jan. 1, 2005, this option is no longer available for new sales. Beginning with 2004 renewals, members will be migrating from gatekeeper programs (BlueCare Plus and BlueCare Plus POS) to comparable non-gatekeeper programs (BlueCare and BlueCare POS).

- **BlueCare POS** - Allows members to obtain care from both participating and non-participating physicians or providers. However, members can maximize their coverage and reduce out-of-pocket expenses when seeking treatment from participating physicians. As this is a non-gatekeeper program, PCP referrals are not required.

### Primary Care Physicians

Each of these programs require or recommend (depending on the program) that members select a primary care physician. The PCP will be most familiar with their patients’ health status and will provide all routine care. In addition, some programs, such as BlueCare Plus and BlueCare Plus POS, require that members obtain a referral from their PCP when obtaining specialty care from a participating specialist.

### Coverage Options

In order to meet the needs of our employer group clients, each of these programs offer varying cost share options. For your reference, a sample benefit description is provided for BlueCare Plus, BlueCare, BlueCare POS, BlueCare Plus POS.

### Standard BlueCare Health Plan HMO Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Type of Service</th>
<th>Preventive/PCP care</th>
<th>Per Admission/Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare Plus (Gatekeeper)</td>
<td>Preventive</td>
<td>$0, $5, $10, $15, $20, $30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>PCP/Specialty Care</td>
<td>$5, $10, $15, $20, $30</td>
<td></td>
</tr>
<tr>
<td>BlueCare (Non-Gatekeeper)</td>
<td>Preventive/PCP care</td>
<td>$0, $5, $10, $15, $20, $30</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty Care</td>
<td>$15, $20, $25, $30, $45</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Per Admission/Hospital</td>
<td>$0, $250, $500, $50 per day up to $250 per stay &amp; $750/year &amp; $500 per day up to $2,000 per stay &amp; $6,000/year</td>
<td></td>
</tr>
</tbody>
</table>

* Outpatient Surgery Copay Options: $0, $50, $100, $150, $200, $500
Standard BlueCare Health Plan POS Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Out-of Network</th>
<th>Coinsurance</th>
<th>Coinsurance Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>BlueCare Plus POS*</td>
<td>Deductible</td>
<td>$250 ind./</td>
<td>$1,500 ind./</td>
</tr>
<tr>
<td>(Gatekeeper)</td>
<td></td>
<td>$500 2</td>
<td>$2,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>person</td>
<td>$4,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td>$6,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$750 3+</td>
<td>$2,500 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family</td>
<td>$5,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$7,500 3+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>family</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>80%/20%</td>
<td>70%/30%</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
<tr>
<td>BlueCare POS*</td>
<td>Deductible</td>
<td>$250 ind./</td>
<td>$1,500 ind./</td>
</tr>
<tr>
<td>(Non-Gatekeeper)</td>
<td></td>
<td>$500 2</td>
<td>$2,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>person</td>
<td>$4,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>/</td>
<td>$6,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$750 3+</td>
<td>$2,500 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td>family</td>
<td>$5,000 ind./</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$7,500 3+</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>family</td>
</tr>
<tr>
<td></td>
<td>Coinsurance</td>
<td>80%/20%</td>
<td>70%/30%</td>
</tr>
<tr>
<td></td>
<td>Maximum</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Out-of-network lifetime maximum $1,000,000.

State BlueCare POE, Plus POE and POS

- **State BlueCare POE** - A program for State of Connecticut employees which provides benefits when care is provided by participating physicians and other health care providers only. As this is a non-gatekeeper program, PCP referrals are not required.

- **State BlueCare Plus POE** - A program for State of Connecticut employees which provides benefits when care is provided by participating physicians and other health care providers only. As this is a gatekeeper program, PCP referrals are required.

- **State BlueCare POS** - A program for State of Connecticut employees which allows members to obtain care from both participating and non-participating physicians or other health care providers. By seeking treatment from participating providers, members can maximize their coverage and reduce out-of-pocket expenses. As this is a non-gatekeeper program, PCP referrals not required.

BlueCare Basic and BlueCare Plus Basic

BlueCare programs which provide more affordable health insurance benefits to small employer groups, and are served by physicians and other health care professionals participating in the BlueCare Health Plan network. For BlueCare Plus Basic, PCP referrals are required.

BlueCare Direct and BlueCare Plus Direct

BlueCare programs which offer health care coverage to individuals, and are served by providers in the BlueCare Health Plan network. For BlueCare Plus Direct PCP referrals are required.

Non-Standard BlueCare Health Plan Programs

In addition to these BlueCare Health Plan programs, Anthem provides the option of non-standard benefit programs to large employer groups. If you have a question regarding a member’s coverage in a non-standard program, please contact the Provider Call Center.
3. New England Health Plans  
(Formerly HMO New England)  

*From the New England Managed Care Initiative (NEMCI)*  

**HMO Blue New England** and **BlueChoice New England**

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMO Blue New England and BlueChoice New England</td>
<td>1</td>
</tr>
<tr>
<td>Key Telephone Numbers</td>
<td>2</td>
</tr>
<tr>
<td>Benefit Programs</td>
<td>2</td>
</tr>
<tr>
<td>Prefix Codes</td>
<td>3</td>
</tr>
<tr>
<td>Identification Card</td>
<td>4</td>
</tr>
<tr>
<td>Office Procedures and Referrals</td>
<td>5</td>
</tr>
<tr>
<td>Office Visit Procedure</td>
<td>5</td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>5</td>
</tr>
<tr>
<td>Referrals</td>
<td>5</td>
</tr>
<tr>
<td>Referring PCPs</td>
<td>6</td>
</tr>
<tr>
<td>Specialists</td>
<td>6</td>
</tr>
<tr>
<td>Obstetrician/Gynecologists</td>
<td>6</td>
</tr>
<tr>
<td>Behavioral Health Care</td>
<td>6</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>7</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>7</td>
</tr>
<tr>
<td>Emergency Admissions Authorization</td>
<td>8</td>
</tr>
<tr>
<td>Emergency Treatment from a Non-Participating Provider</td>
<td>8</td>
</tr>
<tr>
<td>Vision Care</td>
<td>8</td>
</tr>
<tr>
<td>Claim Submission</td>
<td>8</td>
</tr>
<tr>
<td>Compensation</td>
<td>9</td>
</tr>
</tbody>
</table>
New England Health Plans

Anthem Blue Cross and Blue Shield participates in a regional managed care program, New England Health Plans, in cooperation with the five other New England Blue Cross and Blue Shield plans: Maine, Vermont, New Hampshire, Massachusetts and Rhode Island. In Connecticut, members of New England Health Plans access care from the physicians and health care professionals participating in our BlueCare Health Plan network. Anthem’s participation in this program is two-fold, as a:

- **Home Plan** -- When the employer group's headquarters is located in the service area, this area’s plan has the primary responsibility for selling and servicing the account.
- **Host Plan** -- The area in which a member from a Home Plan account selects a primary care physician is responsible for provider and medical management services for the member.

#### Key Telephone Numbers

| Membership/Benefits/Eligibility Inquires | (800) 676-BLUE (2583) nationwide |
| Claims Inquiries | (800) 922-3242 (in Conn.) |
| or (203) 239-3884 (local North Haven) |
| Behavioral Health (ValueOptions) | refer to the phone number on the back of the member’s ID card |
| Utilization Management |
| When a New England Health Plans member selects a PCP from the Connecticut network, the member's care will be coordinated in accordance with BlueCare Health Plan’s utilization management guidelines. To coordinate the appropriate approval for one of these members, use the numbers listed below. If the member’s PCP is located outside of Connecticut, call (800) 676-BLUE to contact the plan in the state where the PCP is located for UM requirements. |
| Prior Authorization of Elective Admissions | (800) 238-2227 (toll free) |
| Emergency Admissions Certification |
| Urgent Care/Emergency Treatment |
| Prior Authorization (outpatient services) | (800) 682-9169 (toll free) |
| Case Management | (203) 231-8254 |

#### Benefit Programs

**HMO Blue New England:**

- **Requires members to select a primary care physician (PCP)** from the provider directory in the state where the member will be accessing health care services. In Connecticut, members select their PCP from the BlueCare Health Plan network.
- **Requires members to obtain all routine care or obtain a referral** from their designated PCP for covered services from a participating specialist.
- **Allows members to change their PCP at anytime.** This change will be effective the first day of the following month.
- No out-of-network benefits.
Blue Choice New England point-of-service (POS) program:

- **Requires each member to select a primary care physician (PCP)** from the directory in the state where the member will be accessing health care services. In Connecticut, members select their PCP from the BlueCare Health Plan network.

- **Encourages members to obtain all routine care or obtain a referral from their PCP** for covered services from a participating specialist. By doing so, members will pay only a small copay for covered services.

- **Allows members to self-refer to participating or non-participating specialists** and still be eligible for coverage with additional cost shares and deductibles.

- **Allows members to change their PCP at anytime.** This change will be effective the first day of the following month.

**Important Networking Note:**

Members who have selected a PCP from another state’s network must obtain out-of-network referrals in order to receive care from a BlueCare Health Plan participating provider. For example, members who have selected a PCP from the Blue Cross & Blue Shield of Massachusetts network will access in-network services from participating specialty physicians or providers in the Massachusetts network. Likewise, members with a BlueCare Health Plan PCP will access in-network services from participating BlueCare Health Plan specialty physicians or providers.

Please see Appendix B for our HMO Member Bill of Rights and the Blue Cross Blue Shield Association Quality Commitments to Managed Care Members

### Prefix Codes

The members’ ID number reflected on the ID card will contain one of the following prefix codes. This code allows you to distinguish the member’s home plan. The third character identifies the type of program: "N" for HMO, and "P" for point-of-service (POS).

<table>
<thead>
<tr>
<th>New England Health Plan ID Numbers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Plan State</strong></td>
</tr>
<tr>
<td>Connecticut</td>
</tr>
<tr>
<td>Maine</td>
</tr>
<tr>
<td>Massachusetts</td>
</tr>
<tr>
<td>New Hampshire</td>
</tr>
</tbody>
</table>
Identification Card

You can expect to see New England Health Plans members with ID cards issued by Anthem and by the other New England Blue Cross and Blue Shield plans. ID cards are issued by the Blue Cross & Blue Shield plan where the employer group headquarters is located. Below is an example of an HMO Blue New England card issued by Anthem in Connecticut.

1. **HMO Blue New England Logo**
   The logo that identifies members of New England Health Plans. You will also see New England Health Plan cards displaying the Network Blue New England or BlueChoice New England logos.

2. **Member Name**
   The full name of the cardholder.

   **Identification Number**
   The member ID number including an alpha prefix.

3. **Copays**
   Copays applicable to the member.

   **Primary Care Physician**
   Information regarding the member’s PCP. On the cards of Anthem members, the PCP name will be displayed if the member has selected a PCP in Connecticut, Maine or New Hampshire. If the PCP selected is in Massachusetts, Rhode Island or Vermont, the name will not be displayed, but the card will indicate the PCP’s location. Cards issued by other states may not display the PCP name.

4. **Group Number**
   Number for member’s employer group.

5. **Suitcase Logo**
   The empty suitcase logo identifies that claims will be handled via the BlueCard inter-plan processing system.
Office Procedures and Referrals

- A referral is required for HMO Blue New England members to access specialty care except in the case of a medical emergency or the need for behavioral health services.

- Blue Choice New England POS members may choose to seek care without a referral; however, they are subject to additional cost shares and deductibles when a referral is not obtained.

Office Visit Procedure

These steps will help ensure quick payment turnaround and help members minimize out-of-pocket expenses. Please note: When a New England Health Plans member selects a PCP from the Connecticut network, the member’s care will be coordinated in accordance with BlueCare Health Plan’s referral and utilization management guidelines.

Primary Care Physician

1) Review ID card or enrollment form as presented by member.
2) Verify eligibility by calling (800) 676-BLUE.
3) Collect copay as listed on card.
4) Copy ID card front and back, and obtain signed release of information to the insurance affiliate.
5) Provide services or care required.
6) **HMO Blue New England:** Members must obtain a referral from their PCP for specialty care. The PCP may refer to any participating physician or provider. To refer a member to an out-of-network or out of state specialty physician or provider, the PCP must obtain prior authorization by contacting the Utilization Management Department at (800) 238-2227.

**Blue Choice New England (POS):** Members of Blue Choice New England are encouraged to obtain all routine care from their designated PCP, or obtain a referral from their PCP to access covered services from a participating physician or provider. By doing so, members will pay only a small copay for covered services. However, members of Blue Choice New England may choose to self-refer to participating or non-participating physicians or providers and still be eligible for coverage with additional cost shares and deductibles.

7) Submit a CMS-1500 Form for payment or file the claim electronically according to the claims filing procedures outlined in the Claims section of this manual.

Referrals

**Blue Choice New England POS**

Members have the option to self-refer for specialty care in this program. However, members of Blue Choice New England are encouraged to obtain all routine care from their designated PCP or obtain a referral from their PCP to access covered services from a participating physician or provider. By doing so, members will pay only a small copay for covered services.

**HMO Blue New England or In-Network Blue Choice New England**

Members of HMO Blue New England must obtain all routine care from the designated PCP or obtain a referral from their PCP to access covered services from a participating physician or provider.
Referring PCPs
If you are referring a member for specialty care:

1) **Make a note in the member’s record** and in your referral log, noting the member’s name, the date of the referral and the specialist to whom the member is being referred.

2) **Contact the office of the specialty provider** to whom you are referring the patient to advise that provider of the member’s name and diagnosis.

   **Important note:** Be sure to give them your UPIN number. This number is required to process claims for referred services.

3) The specialty physician or health care provider will include your name and UPIN number on the claim. This is considered authorization for the referral when they are filing a claim for services rendered to your member/patient.

4) **If you are referring the member to a participating provider who is located outside of Connecticut,** you must call the Utilization Management Department to have the referral logged on our system.

Specialists:
If a member is referred to you:

1) **Follow the office procedures** outlined in this section.

2) **Make a note on the member’s record** or in your referral log, noting the member’s name, the date of referral and the UPIN number of the referring physician.

3) **Indicate the referring PCP’s name** in Box 17 of the CMS-1500 claim form, and his or her UPIN number in Box 17a of the same form, or the appropriate areas when filing electronically. This information must be included for claims to adjudicate accurately.

   **IMPORTANT:** No separate referral form is required. Benefits will be determined based on the information listed in these fields.

4) **You must report back to the referring PCP**
   - after the first consultation to discuss the diagnosis and proposed treatment,
   - periodically during the course of treatment, and
   - at the time specialty treatment is discontinued.

Obstetrician/Gynecologists

(Maternity: Please refer to the “Utilization Management” chapter of this manual for maternity care information.)

- **A female member may self-refer** to a participating OB/GYN for any covered routine OB/GYN exam, care related to pregnancy, and covered primary or preventive OB/GYN services required as a result of a gynecological condition or exam. A referral is required for all other services performed by an OB/GYN, including infertility services.

- Obstetricians/Gynecologists can refer any member for treatment of breast mass, abnormal mammogram, pelvic mass, acute surgical emergency and all specialty services for pregnancy.

- **Blue Choice New England POS only:** Members may go out of network for care; however, services will be subject to coinsurance and deductibles.

Behavioral Health Care

- If a member of New England Health Plans requires behavioral health services, you or the member must call the number on the back of their identification card to locate a participating behavioral health physician or provider.

- Behavioral health services for New England Health Plans members do not require a referral from the PCP.
The Home Plan is responsible for coordinating behavioral health benefits. You will be able to distinguish the member's home plan by referring to the “Prefix Codes” provided on page 3 of this section.*

Connecticut Home Plan members (CTN or CTP) will access the ValueOptions network, which they may do without a referral. New England Health Plans members will not access behavioral health physicians and providers in the BlueCare Health Plan network.

* Always send Behavioral Health claims to the Home Plan for processing, unless an outside vendor is responsible for behavioral health claims.

Utilization Management

When a New England Health Plans member selects a PCP from the Connecticut network, the member's care will be coordinated in accordance with BlueCare Health Plan’s utilization management guidelines. Please refer to the Utilization Management chapter of this manual for specific guidelines including prior authorization of services.

If a member of Blue Choice New England (POS) chooses to go to a non-participating physician or health care provider, it is the member's responsibility to contact their Home Plan to obtain prior authorization, treatment planning or medical management.

Urgent Care

(Please refer to the most recent Physician Directory for a listing of participating hospital-based urgent care centers):

- **No referral is required** for after-hours urgent care. However, members are encouraged to contact their PCP in an urgent situation. Members may self-refer to a participating urgent care facility at any time.
- **A referral is required for a member to access an urgent care facility during office hours.** If a PCP is unable to quickly schedule an appointment with the member, the PCP may refer their patient to a participating urgent care facility during the day.
- The urgent care facility must be participating to be eligible for in-network coverage.
- If you are referring your patient to an urgent care facility during normal office hours, you must contact the urgent care center, preferably before treatment is rendered, but no more than 48 hours after the phone call from the member.
- The PCP must notify the Prior Authorization Department within 48 hours or two business days of the referral at (800) 742-3696 (toll free).
- If the member is admitted to the hospital as a result of a visit to an urgent care facility, the Utilization Management Department must be notified within 48 hours or two business days of the admission at (800) 238-2227.
- Members are responsible for applicable urgent care visit copays.
- Services must meet urgent care criteria. Urgent care refers to services that can be provided for an injury or illness that is not an emergency, but does require immediate attention. Benefits may be denied for urgent care services rendered in conjunction with a condition that is determined to be non-urgent.
- Urgent-care facilities cannot be used as a “back-up” for the PCP; PCPs who act as care coordinators may not “sign out” to a walk-in center for covering purposes.
Emergency Admissions Authorization

- Benefits for emergency care are provided for treatment of a serious illness or injury which, if not treated immediately, could result in disability or death.
- In an emergency situation, members are directed to go immediately to the nearest emergency room and, if possible, to contact their PCP before going.
- Emergency admissions must be reported to the Utilization Management Department within 48 hours or two business days at (800) 238-2227.
- Members are responsible for an emergency room copay for each visit that does not result in the patient being admitted as an inpatient directly from the emergency room.

Emergency Treatment from a Non-Participating Provider

- If a member requires emergency care from a non-participating provider, no prior authorization from the plan or the primary care physician is required.
- The member must contact the PCP to arrange any medically necessary follow-up care as soon as he or she is able.
- The member or admitting physician must report all emergency hospitalizations to the Utilization Management Department within 48 hours, at (800) 238-2227, or the number on the back of the member’s ID card.

Vision Care

When Anthem Blue Cross and Blue Shield in Connecticut is Host Plan

Under all Commercial HMO programs, eye care services are eligible for coverage when performed by a participating BlueCare Health Plan provider. Consult the member's specific plan at the end of this section to determine if a member is eligible for out-of-network benefits and their specific vision benefits (i.e. vision exam coverage, copays and referrals).

- **Referrals and prior authorization are not required for routine eye exams.**
- Prior authorization may be required for some services that are surgical in nature. For prior authorization, call (800) 238-2227.
- Vision Wear Discounts: Anthem members can purchase high quality, brand-name vision wear at discounted prices through our value-added discount program, SpecialOffers@Anthem.

Claim Submission

Claims must be filed no later than 90 days from the date of service to receive timely, direct compensation from Anthem for services you render to a New England Health Plans plan member.

The following claim submission guidelines have been established for those providers participating in more than one state’s health plan.

These guidelines apply when:

- You are participating in BlueCare Health Plan in Connecticut as well as the HMO plan of either Rhode Island or Massachusetts.
- You are not a Primary Care Physician (PCP). Under the New England Health Plan guidelines, if you are a PCP you must select the state in which you wish to be listed as a PCP.
(claim submission guidelines continued)

If You…  You Should…

- Participate in Connecticut and another state with only one office location
  ➔ Submit claims to the Blue Plan of the State where your office is located

- Participate in Connecticut and another state and have offices in both states
  ➔ Submit claims to the Blue Plan of the State where the services are physically rendered

- Participate as PCP
  ➔ Submit claims to the Blue Plan of the State where you are listed as a PCP

- Participating in Connecticut only but have office locations in more than one State
  ➔ Submit claims to the Connecticut plan

Compensation

- You will receive compensation for covered services rendered to New England Health Plans members directly from Anthem when the claim has been appropriately submitted.

- Compensation for covered services rendered in Connecticut to a New England Health Plans member is subject to contracted terms and conditions for BlueCare Health Plan.

- All member copays, deductibles and coinsurance apply, as well as the member's applicable utilization and quality management requirements.

- Compensation for covered services rendered to BlueCare Health Plan network physicians and health care professionals will be made according to the current Comprehensive Schedule of Professional Services, and is considered payment in full.

- You may not balance bill the member, except for member payment responsibilities, such as copays, deductibles and coinsurance.
4. CENTURY PREFERRED PPO

INCLUDES: CENTURY PREFERRED, CENTURY PREFERRED COMP,
CENTURY PREFERRED DIRECT, CENTURY PREFERRED HSA,
CENTURY PREFERRED PCA, AND CENTURY 90

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Telephone Numbers</td>
<td>2</td>
</tr>
<tr>
<td>Program Overview</td>
<td>2</td>
</tr>
<tr>
<td>Identification Card</td>
<td>4</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>5</td>
</tr>
<tr>
<td>Managed Benefits</td>
<td>5</td>
</tr>
<tr>
<td>Prior Authorization of Inpatient and Outpatient Services</td>
<td>5</td>
</tr>
<tr>
<td>Notification of Maternity Admissions</td>
<td>5</td>
</tr>
<tr>
<td>Preventive and Well Care Schedule</td>
<td>5</td>
</tr>
<tr>
<td>Behavioral Health Treatment</td>
<td>6</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>6</td>
</tr>
<tr>
<td>Expedited Review Hotline - Inpatient Care</td>
<td>6</td>
</tr>
<tr>
<td>Emergency Admissions Authorization</td>
<td>7</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>7</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>7</td>
</tr>
<tr>
<td>Clinical Transition Program</td>
<td>7</td>
</tr>
<tr>
<td>Case Management</td>
<td>8</td>
</tr>
<tr>
<td>Laboratory</td>
<td>8</td>
</tr>
<tr>
<td>Benefit Programs</td>
<td>8</td>
</tr>
</tbody>
</table>
Program Overview

The Anthem Blue Cross and Blue Shield’s Century Preferred programs are Preferred Provider Organization (PPO) programs that include utilization management guidelines to create high-value, cost effective benefit packages.

Program Highlights

The Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, and Century Preferred HSA and Direct HSA plans include the following:

- A statewide panel of physicians and health care providers who provide in-network services at significant cost savings to the member.
- Out-of-network benefits, subject to deductibles and higher coinsurance.
- Benefits that include a broad range of inpatient and outpatient coverage for hospitalization and medical/surgical services.
- Lower out-of-pocket costs when members use participating physicians and health care providers.
- Direct compensation to participating physicians and other health care providers when covered services are rendered.
- Utilization management criteria.
If you provide more than one surgical procedure service for a patient in the same day, approved consecutive procedures will be paid at different levels. The first highest allowance will be paid at 100 percent of the maximum allowable amount, and the second will be paid at 50 percent of the MAA. There is no compensation for the third and consecutive procedures provided that same day.

The Century Preferred HSA (Health Savings Account) and Century Preferred Direct HSA plans combine a Century Preferred (PPO) high-deductible health plan with a tax-favored health savings account that allows consumers to use checks and debit cards to pay for qualified medical expenses.

With these plans, employers, employees and individual members can deposit money into eligible members’ health savings accounts up to the level of the deductible or up to limits set by federal law. The member may then use his or her HSA funds to pay for qualified medical expenses until the deductible is reached. Once the deductible is met, the member’s health services are covered according to his or her health plan.

The Century Preferred HSA and Century Preferred Direct HSA benefit plans are served by the Century Preferred provider network and cover both in and out of network care. However, in the HSA plans, an upfront deductible is applied for both in and out of network services, as well as coinsurance, which will vary depending on the plan selected.

The Century 90 plan, and it’s endorsements, when offered in conjunction with any semi-private hospital plan:

- Serves members through the Century Preferred network.
- Provides basic medical/surgical benefits to members for covered services.
- Includes a Managed Benefits component when selected by the employer group.
- Allows groups to purchase riders that provide benefits for home and office visits, including Century 94, Century 96, and/or vision benefits, including Century 98, Century 9D, Century 9T. A member copayment may be required when these services are rendered.
- Offers direct compensation to participating physicians and other health care professionals when covered services are rendered.
- If you provide more than one surgical procedure service for a patient in the same day, approved consecutive procedures will be paid at different levels. The first highest allowance will be paid at 100 percent of the maximum allowable amount, and the second will be paid at 50 percent of the MAA. There is no compensation for the third and consecutive procedures provided that same day.

BlueCard PPO Program

The national Blue Cross and Blue Shield Association provides an out-of-area claims processing program for members of other Blue Cross and Blue Shield plans in the country. This program, the BlueCard Program, provides direct, timely compensation to Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, Century Preferred HSA and Direct HAS, and Century 90 participating physicians and health care providers for services rendered to members of out-of-state Blue Cross and Blue Shield plans. This system is designed to reduce your administrative burden by allowing you to submit out-of-area Blue Cross and Blue Shield claims directly to Anthem for processing. For further information, see the BlueCard chapter of this manual.

Non-standard Coverage - “Carve-outs”

Employer groups covered by any of our products or programs may opt to “carve-out” specific portions of that coverage. Under these circumstances, the following could occur:

- Specific benefit(s) may not be covered that are covered under the standard plan.
- A specific area of coverage (such as behavioral health) may be provided by a network of providers other than the standard plan network (an example would be a behavioral health vendor’s network taking the place of Anthem’s Century Preferred network or behavioral health providers.)

Information on carve-outs from standard plans may be printed on the member’s ID card. For further information on specific employee group coverage, contact the Provider Call Center at (800) 922-3242 (toll free in Connecticut), or (203) 239-3884 (local North Haven).
IMPORTANT NOTES:

- **Participating providers must refer members to other participating providers.** If this requirement is not followed, Anthem may deny payment, and the member will be held harmless.

- **Participating providers may not balance bill a member when the claim is denied because of lack of medical necessity.** Neither Anthem nor the member is responsible for care that is determined to be medically unnecessary. The member may only be balance billed for these services if the provider secures the member's consent to the care in advance of receiving it, and documents that consent, including the disclosure that the care will not be covered under the member's health plan.

- **Members may not be held financially responsible for any amounts in excess of the contracted rate** (i.e. balance billed for the amount between the contracted rate and the provider's charge).

### Identification Card

- Century Preferred
- Century Preferred Comp and PCA
- Century Preferred Direct
- Century Preferred HSA
- Century Preferred Direct HSA
- Century 90(with empty suitcase logo)

<table>
<thead>
<tr>
<th>1. <strong>Member Name</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The full name of the cardholder.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>2. <strong>Identification Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The number used to identify each Anthem Blue Cross and Blue Shield member. Be sure to check this number at each visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>3. <strong>Health Plan Details</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The name of the health plan and the type of coverage; usually lists any copay amounts, frequency limits or annual maximums for home and office visits; may also list the member's annual deductible amount. Pharmacy Coverage and Dental Coverage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>4. <strong>Group Identification Number</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The 9-digit number used to identify the member's employer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>5. <strong>PPO Suitcase Logo</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicating the plan is a BlueCard product</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>6. <strong>Blue Cross &amp; Blue Shield Plan Codes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>The numbers used to identify the codes assigned to each plan by the Blue Cross &amp; Blue Shield Association; used for claims submission when medical services are rendered out-of-state.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>7. <strong>Anthem Prescription</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Indicates the member is enrolled in a prescription drug program.</td>
</tr>
</tbody>
</table>

*Always remember to check the back of the ID card for important information.*
Utilization Management

(Utilization management parameters for in-network services)

IMPORTANT NOTE:

Providers participating in our Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, Century Preferred HSA and Century 90 programs may not balance bill a member when the claim is denied because of lack of medical necessity. Neither Anthem nor the member is responsible for care that is determined to be medically unnecessary. The member may only be balance billed for these services if the provider secures the member’s consent to the care in advance of receiving it, and documents that consent, including the disclosure that the care will not be covered under the member’s health plan.

Managed Benefits

Please see the “Managed Benefits” section of the Utilization Management chapter of this manual for Managed Benefits requirements for Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, Century Preferred HSA and Century 90 members.

Prior Authorization of Inpatient and Outpatient Services

Prior authorization is required for a variety of services for Century Preferred members. Prior authorization phone numbers are listed in the Key Telephone Numbers section at the front of this chapter. Additional information can be found in the “Prior Authorization” section of the Utilization Management chapter.

Notification of Maternity Admissions

Please see the “Maternity Admission Notification” section of the Utilization Management chapter of this manual for maternity notification information for Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, Century Preferred HSA and Century 90 members.

Preventive and Well Care Schedule

<table>
<thead>
<tr>
<th>Pediatric</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth - 1 year - 6 exams</td>
<td>22-29 years - 1 exam / 5 years</td>
</tr>
<tr>
<td>1-5 years - 6 exams</td>
<td>30-39 years - 1 exam / 3 years</td>
</tr>
<tr>
<td>6-10 years - 1 exam / 2 years</td>
<td>40-49 years - 1 exam / 2 years</td>
</tr>
<tr>
<td>11-21 year - 1 exam per year</td>
<td>50 years + - 1 exam per year</td>
</tr>
</tbody>
</table>

Vision Exam
Covered once every 24 months.

Hearing
Covered once every 24 months.

Routine Gynecological
Covered once every year.

Mammography
35-39 yrs (inclusive)- One baseline screening
40 and older - One per year.
Additional exams when medically necessary
Behavioral Health Treatment

Behavioral Health services for Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct and Century Preferred HSA members are provided through the Century Preferred network, and benefits are administered by Anthem Behavioral Health. No referral is required. However, if you wish to refer Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct and Century Preferred HSA members for emergent or non-urgent behavioral health services, you may call (800) 934-0331 (24 hours).

Please Note:
- Mohegan Sun members access behavioral health services through ValueOptions, Inc. For more information call the telephone number on the back of the member’s ID card.
- Taft-Hartley (Teamsters) members have varying benefit and plan requirements. Check the member’s ID card, or contact the dedicated Taft-Hartley Fund Service Unit at (800) 287-0032.

Mental Health Parity Legislation

State of Connecticut and Federal legislation mandating parity for mental health services is affecting the benefits for members covered under Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct and Century Preferred HSA.

Under state law, insured benefit plans are required to provide coverage for the diagnosis and treatment of mental or nervous conditions (including treatment for substance abuse) on the same basis as other medical services covered under the health plan. The Plan cannot place a greater financial burden on an insured for access to this type of service than for the diagnosis or treatment of medical, surgical or other physical health conditions. Excluded from this requirement is treatment related to:
- Mental retardation
- Learning disorders
- Motor skills disorders
- Communication disorders
- Caffeine-related disorders
- Relational problems
- Additional conditions that may be a focus of clinical attention, that are not otherwise defined as mental disorders in the most recent edition of the American Psychiatric Association’s “Diagnostic and Statistical Manual of Mental Disorders”

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

Please see the benefit matrix at the end of this chapter for specific mental health benefit information.

Durable Medical Equipment

DME Prior Authorization

Call the Provider Call Center at (800) 922-3242 to determine if the DME request is eligible for coverage, and if prior authorization is required.

Expedited Review Hotline - Inpatient Care

Participating providers have access to an “expedited review hotline” designed for emergent/life threatening situations. If a member has been admitted to a hospital, and the physician feels that the member’s life would be in danger, or illness could occur if the patient is discharged or treatment is delayed, the physician may contact Utilization Management and request an expedited review.

A UM nurse is on call from 8:00 a.m. through 9:00 p.m., seven days a week to handle these requests. If the physician does not receive a response from Utilization Management within 3 hours from the time the call is made, the admission/extension is considered approved.

For expedited review, call toll free (888) 507-8803, or, if busy, (888) 506-2272.
Emergency Admissions Authorization

- Hospital admissions resulting from covered emergency room treatment are subject to the Managed Benefits guidelines described in the “Utilization Management” section of this manual.
- Benefits for emergency care are provided for treatment of the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is needed.
- There is a copay for the use of the emergency room facility. This copay is waived if the member’s visit to the emergency room results in immediate admission to the hospital.

Urgent Care

*Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct and Century Preferred HSA* members have access to a comprehensive, hospital-based urgent care network for urgent care 24 hours a day, 7 days a week. For a list of participating urgent care facilities please refer to the *Century Preferred* provider directory online at anthem.com.

The facilities provide:
- **Triage service** - Medical professionals determine if the patient requires emergency or urgent care. Access to the emergency room is available when medically necessary.
- **Shorter wait times** - 90% of members must be seen within 60 minutes.
- **Access to hospital facilities** - available hospital equipment, technologies and other on-site ancillary services including x-ray, laboratory and pharmacy.
- **Quality monitoring** via provider audits and satisfaction surveys.

To be eligible for in-network coverage, members may simply access urgent care from a participating urgent care facility. Members may elect to go out-of-network to obtain care; however, they will be responsible for additional cost sharing, such as deductibles and coinsurance.

Concurrent Review

Concurrent review is the process through which a patient’s ongoing care is evaluated as the care is being provided. This is achieved through the coordinated efforts of the Concurrent Review Department, the hospital, the physician, the patient and the consulting physician reviewers. The focus of concurrent review is to better manage the continuity of the member’s care from the acute care setting to the subacute level of care. For more information on the concurrent review process, call (800) 238-2227 (in Conn.) or (800) 248-2227 (out of state).

Clinical Transition Program

This program is designed to aid the member who is transitioning into an Anthem health plan from another health plan by providing cost-effective, personalized care. A nurse consultant will facilitate ongoing medical and behavioral health care and transition the care into the member’s new provider network and benefit design.

The new member will be assisted with the appropriate components of the Utilization Management program, including prior authorization, notification of emergency or urgent care, concurrent review, case management, specialty referrals and behavioral health management (mental health/substance abuse).

**The Goals of Clinical Transition are to:**
- Facilitate a smooth transition into the member’s new health plan.
- Identify complex health care problems.
- Assist members in maintaining well-coordinated, quality health care and benefit options.
- Minimize lapses in our members’ health care.

Detailed information on the Clinical Transition program can be found in the *Utilization Management* chapter of this manual under “Clinical Transition”.
Case Management

The process through which members who have extremely complex or costly medical problems are evaluated, on a case-by-case basis, to determine if there are care options that can be tailored in a cost-effective manner. For more information see the Utilization Management section of this manual under "Community Case Management Programs", or call (800) 231-8254.

The case management program will:

- Assist members in moving from the hospital to the community.
- Emphasize comprehensive care.
- Manage costs through enhanced management of health outcomes.
- Promote self-care, where appropriate, for the chronically ill and their significant others.

Whenever appropriate, Anthem provides case management for members who experience an extremely complex and costly medical problem as a result of an accident, catastrophic illness or recurring condition, as well as for members with chronic disease who might benefit from coordination of services. This process is supported by a concurrent review of medical records, and collaboration with the medical team providing care to identify those patients who will need community services after discharge.

Laboratory

Refer to the Century Preferred provider directory online at anthem.com for a list of participating laboratories.

Benefit Programs

Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, and Century Preferred HSA are preferred provider organization (PPO) programs that offer a number of cost share options to meet the varying needs of our employer clients. The following is an overview of the standard Century Preferred, Century Preferred Comp and Century Preferred Direct options.

**Century Preferred Standard Options**

<table>
<thead>
<tr>
<th>Office Visit Copays:</th>
<th>$5, $10, $15, $20 or $30</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Surgery</td>
<td>$0, $50, $100, $150, $200 or $500</td>
</tr>
<tr>
<td>Emergency Room Copays:</td>
<td>$0, $25, $50, $75 or $150</td>
</tr>
<tr>
<td>Per Admission Copays:</td>
<td>$0, $50 per day up to $250 per stay and $750 per year, $250, $500 per day up to $2,000 per stay and $6,000 per year.</td>
</tr>
</tbody>
</table>

**Century Preferred Comp Standard Options**

<table>
<thead>
<tr>
<th>In-Network Member Pays</th>
<th>Out-of-Network Member Pays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coinsurance: 10%</td>
<td>30%</td>
</tr>
<tr>
<td>OR 20%</td>
<td>40%</td>
</tr>
</tbody>
</table>

**Deductibles Options:**

- $100 Individual/$200 2-person family/$300 family - 3 or more
- $200 Individual/$400 2-person family/$600 family - 3 or more
- $250 Individual/$500 2-person family/$750 family - 3 or more
- $400 Individual/$800 2-person family/$1,200 family - 3 or more
- $500 Individual/$1,000 2-person family/$1,500 family - 3 or more
- $1,000 Individual/$2,000 2-person family/$3,000 family – 3 or more
- $2,000 Individual/$4,000 2-person family/$6,000 family – 3 or more
- $3,000 Individual/$6,000 2-person family/$9,000 family – 3 or more
- $5,000 Individual/$10,000 2-person family/$15,000 family – 3 or more
Coinsurance Maximums:
- $800 Individual/$1,600 2-person family/$2,400 family – 3 or more
- $900 Individual/$1,800 2-person family/$2,700 family – 3 or more
- $1,000 Individual/$2,000 2-person family/$3,000 family - 3 or more
- $1,250 Individual/$2,500 2-person family/$3,750 family - 3 or more
- $1,500 Individual/$3,000 2-person family/$4,500 family - 3 or more
- $1,600 Individual/$3,200 2-person family/$4,800 family - 3 or more
- $2,000 Individual/$4,000 2-person family/$6,000 family - 3 or more
- $2,500 Individual/$5,000 2-person family/$7,500 family - 3 or more
- $4,000 Individual/$8,000 2-person family/$12,000 family – 3 or more
- $6,000 Individual/$12,000 2-person family/$18,000 family – 3 or more
- $10,000 Individual/$20,000 2-person family/$30,000 family – 3 or more

**Century Preferred Direct Standard Options**

**Deductibles Options:**
- $250 Individual/$500 family
- $500 Individual/$1,000 family
- $1,500 Individual/$3,000 family
- $5,000 Individual/$10,000 family
- $10,000 Individual/$20,000 family

**Coinsurance Maximums:**
- $1,000 Individual/$2,000 family
- $1,250 Individual/$2,500 family
- $1,500 Individual/$3,000 family
- $5,000 Individual/$10,000 family
- $10,000 Individual/$20,000 family

For your reference, standard Century Preferred, Century Preferred Comp, Century Preferred Direct, Century Preferred PCA and Century Preferred HSA benefit descriptions have been provided on the following pages. To determine other levels of coverage, refer to the above.

**Non-Standard Programs**

In addition to the standard programs, Anthem Blue Cross and Blue Shield provides the option of non-standard Century Preferred, Century Preferred Comp and PCA, Century Preferred Direct, and Century Preferred HSA benefit programs to large employer groups. If you have a question regarding a member’s coverage or a non-standard program, please contact the Provider Call Center.
5. STATE PREFERRED

Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Key Telephone Numbers</td>
<td>2</td>
</tr>
<tr>
<td>Benefit Program</td>
<td>2</td>
</tr>
<tr>
<td>Member Identification Card</td>
<td>3</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>3</td>
</tr>
<tr>
<td>Managed Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Prior Authorization of Inpatient Admissions</td>
<td>4</td>
</tr>
<tr>
<td>Prior Authorization of Outpatient Services</td>
<td>5</td>
</tr>
<tr>
<td>Preventive and Well Care Schedule</td>
<td>5</td>
</tr>
<tr>
<td>Behavioral Health Treatment</td>
<td>5</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>6</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>6</td>
</tr>
<tr>
<td>Clinical Transition Program</td>
<td>6</td>
</tr>
<tr>
<td>Emergency Admissions Authorization</td>
<td>6</td>
</tr>
<tr>
<td>Urgent Care</td>
<td>6</td>
</tr>
<tr>
<td>Community Case Management Programs</td>
<td>7</td>
</tr>
<tr>
<td>Laboratory</td>
<td>7</td>
</tr>
</tbody>
</table>
Key Telephone Numbers

Claim, Benefit and Membership Inquiries
(Provider Call Center) (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven)

Laboratory
Quest Diagnostics (800) 225-7483

Utilization Management

Anthem Behavioral Health (888) 605-0580 (toll-free, 24 hours)
Case Management (800) 231-8254
Clinical Transition (203) 239-8649
Emergency Admissions Authorization and Urgent Care (800) 238-2227

Expedited Review Hotline (888) 507-8803, or, if busy, (888) 506-2272

Prior Authorization/Notification Inpatient:
- Inpatient Admissions (800) 238-2227
- Transplants
- Maternity Notification - fax (203) 985-7388

Prior Authorization, Outpatient
- Anthem Behavioral Health (888) 605-0580 (toll-free, 24 hours)
- Diagnostic Radiology Services (NIA) Notification only (888) 864-7237
- DME/Prosthetics (call for coverage eligibility) (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven)
- Specified Outpatient Surgeries (800) 238-2227

Benefit Program

Program Highlights

- A statewide network* of physicians and health care professionals who provide in-network services at significant cost savings to the member.
  * State Preferred members access the Century Preferred professional provider network with some exceptions, such as chiropractic and laboratory services. The State Preferred Provider Directory is available on our Web site at anthem.com.
- A broad range of inpatient and outpatient coverage for hospitalization and medical/surgical services.
- Lower out-of-pocket costs when members use participating physicians and health care providers.
- Direct compensation to participating physicians and other health care providers when services eligible for coverage are rendered.
- Out-of-network benefits subject to deductibles, higher coinsurance amounts, and any payment for charges above the Maximum Allowable Charge.
- Members must comply with all utilization and clinical quality management guidelines.
Member Identification Card

State Preferred

The State Preferred Member ID card will look the same as the Century Preferred ID card, but will include State Preferred as the plan name and the State of Connecticut Logo (left). A picture of the Century Preferred card can be found on page 4-4 of the Century Preferred manual chapter.

Utilization Management

Managed Benefits

Managed Benefits is a key feature of the State Preferred program. For the member to receive maximum benefits under their program, the Managed Benefits requirements outlined below must be followed.

- When covered services are provided or arranged by a participating provider, the participating provider must obtain prior authorizations when required.
- If Managed Benefits requirements are not followed, benefits will be reduced in accordance with established non-compliance reductions. Benefits may also be denied for non-medically necessary days and the associated physician services.

The member or his/her representative, the member's physician or the hospital must contact Anthem in accordance with the following guidelines:

In-Network Care: The physician or hospital is responsible for calling the Utilization Management Department at (800) 238-2227.

Out-of-Network Care: It is the member’s responsibility to call the Dedicated Customer Action Team at (800) 922-2232.

The call must be made:

- BEFORE any scheduled inpatient admission, regardless of the reason, no later than one business day before entering the hospital.
- BEFORE any scheduled surgery for the procedures outlined under “Prior Authorization” in the Utilization Management section of this manual.
- AFTER an inpatient admission for any emergency or urgent treatment. This call must be placed within 48 hours or two business days after being admitted.

All telephone calls required under Managed Benefits should be made during regular business hours from 8 a.m. to 5 p.m., Monday through Friday. If a telephone call cannot be made during regular business hours, the member or provider may leave their name, telephone number and message. Their call will be returned the next business day.
IMPORTANT NOTE:

Providers participating in our State Preferred program may not balance bill a member when the claim is denied because of lack of medical necessity. Neither Anthem nor the member is responsible for care that is determined to be medically unnecessary. The member can only be balance billed for these services if the provider secures the member’s consent to the care in advance of receiving it, and documents that consent, including the disclosure that the care will not be covered under the member’s health plan.

Prior Authorization of Inpatient Admissions

All inpatient admissions to a general hospital, specialty hospital, substance abuse treatment facility or residential treatment facility are reviewed to authorize the specific number of inpatient days that will be covered as medically necessary care. All hospitalizations will be subject to a Concurrent Review (see page 5-6).

Prior Authorization Telephone Numbers for inpatient admissions:
(Utilization Management Department)
- (800) 238-2227 (in Connecticut).
- Anthem Behavioral Health (800) 605-0580, 24 hours, specialty hospital, substance abuse treatment facility or residential treatment facility

Contact the Utilization Management Department to obtain prior authorization when you intend to render inpatient services for any elective or emergent surgical procedure. This includes, but is not limited to organ transplants, skilled nursing facility care and subacute care.

In State or Out of State (Out-of-network)
- Prior authorization is required for elective hospital admissions before the member enters the hospital and within 48 hours or two business days of emergency admissions in out-of-network situations.
- Elective, non-emergency admissions must be prior authorized.
- Maternity admissions do not require prior authorization. However, notification of maternity admissions is requested. See the Utilization Management chapter of this manual for Maternity Notification information.
- When an elective inpatient admission is scheduled by an out-of-network physician, notification is the member’s responsibility. However, the physician, hospital or member may notify Anthem.
- Failure to notify according to the above requirements will result in a penalty of 20% or up to $500 per admission.

In State
- In-network: Hospital or physician will call to prior authorize on the member’s behalf.
- Out-of-network: Member, physician or facility must call to prior authorize admission.
- If prior authorization is not obtained, the member will be responsible for all charges if the services are not medically necessary.
- A medically necessary inpatient admission that is not prior authorized will result in an admission penalty of 20% up to $500.

Out of State (In or out-of-network)
- Admissions must be prior authorized by member, physician or facility.
- If not prior authorized, the member will be responsible for all charges if services received are not medically necessary, or for an admission penalty of 20% or up to $500 if admission is medically necessary but not prior authorized.
Prior Authorization of Outpatient Services

Prior authorization must be obtained for the following services:

- Behavioral Health Treatment
- DME & Prosthetic Devices
- Outpatient Surgery, specified in the “Prior Authorization” section of the Utilization Management chapter of this manual

**In State** (in or out-of-network)

- **In-network:** The physician or health care provider must call to prior authorize services on our member’s behalf.
- **Out-of-Network:** The member, physician or facility is required to prior authorize services. If prior authorization is not obtained, the member will be responsible for all charges if the services are determined not to be medically necessary.

**Out of State** (in or out-of-network)

- If not prior authorized, the member will be responsible for all charges if services received are determined not to be medically necessary.
- The provider may call for prior authorization on the member’s behalf.

### Preventive and Well Care Schedule

<table>
<thead>
<tr>
<th>Pediatric</th>
<th>Adult</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth - 1 year - 6 exams</td>
<td>22-29 years - 1 exam / 5 years</td>
</tr>
<tr>
<td>1-5 years - 6 exams</td>
<td>30-39 years - 1 exam / 3 years</td>
</tr>
<tr>
<td>6-10 years - 1 exam / 2 years</td>
<td>40-49 years - 1 exam / 2 years</td>
</tr>
<tr>
<td>11-21 year - 1 exam per year</td>
<td>50 years + - 1 exam per year</td>
</tr>
</tbody>
</table>

**Vision Exam**
Covered once per calendar year.

**Hearing**
Covered once per calendar year.

**Routine Gynecological**
Covered once every year.

**Mammography**
35-39 yrs (inclusive)- One baseline screening
40 and older - One per year.
Additional exams when medically necessary

### Behavioral Health Treatment

Behavioral Health services for State Preferred members are provided through the Century Preferred network, and benefits are administered by Anthem Behavioral Health. No referral is required. However, if you wish to refer State Preferred members for emergent or non-urgent behavioral health services, you may call (888) 605-0580 (24 hours).

- For outpatient visits, the participating provider is required to submit an Outpatient Treatment Report (OTR) after a specified number of pass-through visits have occurred.
- Prior authorization is required for inpatient admission and may be requested by calling (888) 605-0580 (24 hours).
- In emergency situations Anthem must be notified as soon as possible, but no later than 48 hours after the admission.
Durable Medical Equipment

DME Prior Authorization
Call the Provider Call Center at (800) 922-3242 to determine if the DME request is eligible for coverage and whether prior authorization is required.

Concurrent Review

Concurrent review is the process through which a member’s ongoing care is evaluated as the care is being given. This is achieved by the Concurrent Review Department working with the hospital, the physician, the patient and the consulting physician reviewers. The focus of concurrent review is to better manage the continuity of the member’s care from the acute care setting to a lesser level of care, including Home Health Care services.

Clinical Transition Program

This program is designed to aid the member who is transitioning into an Anthem health plan from another health plan by providing cost-effective, personalized care.

For more information see the “Clinical Transition Program” section of the Utilization Management chapter of this manual.

Emergency Admissions Authorization

- Hospital admissions resulting from covered emergency room treatment are subject to the Managed Benefits guidelines described on page 5-3.
- Benefits for emergency care are provided for treatment of the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is needed.
- There is no copay for a medical emergency

Urgent Care

State Preferred members have access to a comprehensive, hospital-based urgent care network for urgent care 24 hours a day, seven days a week. For a list of participating urgent care facilities, please see the Century Preferred provider directory.

The facilities provide:
- **Triage service** - Medical professionals determine if the patient requires emergency or urgent care. Access to the emergency room is available when medically necessary.
- **Shorter wait times** - 90% of members must be seen within 60 minutes.
- **Access to hospital facilities** - available hospital equipment, technologies and other on-site ancillary services including x-ray, laboratory and pharmacy.
- **Quality monitoring** via provider audits and satisfaction surveys.

To be eligible for in-network coverage, members may simply access urgent care from a participating urgent care facility.

For additional information on urgent care services please see the “Urgent Care” section in the Utilization Management chapter of this manual.
Community Case Management Programs

Whenever appropriate, Anthem provides case management for members who experience an extremely complex and costly medical problem as a result of an accident, catastrophic illness or recurring condition, as well as for members with chronic disease who might benefit from coordination of services. This process is supported by the performance of a concurrent review of medical records, and collaboration with the medical team providing care to identify those patients who will need community services after discharge.

For more information see the “Community Case Management” section of the Utilization Management chapter of this manual.

Laboratory

Quest Diagnostic Laboratories

For the State Preferred program, diagnostic lab services are eligible for coverage in-network. All outpatient clinical laboratory and pathology services for State Preferred are provided by Quest Diagnostic Laboratories, Clinical Laboratory Partners LLC, University of Connecticut School of Medicine Laboratories, pathologists and a consortium of more than 30 participating hospital-affiliated laboratories. Under this arrangement, participating physicians and health care professionals may refer State Preferred members, or send their specimens, to one of these designated laboratories for service.

For lab sites call: Quest Diagnostics: (800) 225-7483.

In-Office Lab Services

Laboratory services performed by participating physicians for State Preferred members are eligible for coverage. These services are compensated at 75% of the Century Preferred base fee schedule for laboratory services.
# 6. COMPREHENSIVE & INDEMNITY PLANS

## Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Indemnity Programs</td>
<td>2</td>
</tr>
<tr>
<td>Comprehensive Programs</td>
<td>2</td>
</tr>
<tr>
<td>Group &amp; Direct-pay Comprehensive</td>
<td>2</td>
</tr>
<tr>
<td>Major Medical</td>
<td>3</td>
</tr>
<tr>
<td>Small Employer Programs</td>
<td>3</td>
</tr>
<tr>
<td>Small Employer Comprehensive Plan</td>
<td>3</td>
</tr>
<tr>
<td>Small Employer Hospital/Medical/Surgical/Major Medical</td>
<td>3</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>3</td>
</tr>
<tr>
<td>Managed Benefits</td>
<td>3</td>
</tr>
<tr>
<td>Other Utilization Management Programs</td>
<td>4</td>
</tr>
<tr>
<td>Concurrent Review</td>
<td>4</td>
</tr>
<tr>
<td>Emergency Admissions Authorization</td>
<td>4</td>
</tr>
</tbody>
</table>
Key Telephone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim, Benefits and Membership Inquiries</td>
<td>(800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven)</td>
</tr>
<tr>
<td>(Provider Call Center)</td>
<td></td>
</tr>
<tr>
<td>Utilization Management</td>
<td></td>
</tr>
<tr>
<td>Behavioral Health</td>
<td>(800) 253-9875</td>
</tr>
<tr>
<td>Case Management</td>
<td>(203) 231-8254</td>
</tr>
<tr>
<td>Clinical Transition</td>
<td>(203) 239-8649</td>
</tr>
<tr>
<td>Emergency Admissions Authorization and Urgent Care</td>
<td>(800) 238-2227</td>
</tr>
<tr>
<td>Expedited Review Hotline</td>
<td>(888) 507-8803, or, if busy, (888) 506-2272</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td>(800) 238-2227</td>
</tr>
<tr>
<td>• Inpatient Admissions</td>
<td></td>
</tr>
<tr>
<td>• Specified Outpatient Surgeries</td>
<td></td>
</tr>
<tr>
<td>• Transplants</td>
<td></td>
</tr>
</tbody>
</table>

Indemnity Programs

Anthem offers a number of indemnity programs offering basic hospital and medical/surgical coverage. A Managed Benefits component will apply when selected by the employer group (see page 6-4). This will be indicated on the member’s ID card.

Comprehensive Programs

Anthem offers two programs designed to provide members with a comprehensive benefits package:

- Group & Direct Pay Comprehensive
- Major Medical

Note: There is no provider network associated with these programs. Members are responsible for certain cost-share features and Managed Benefits may apply (see page 6-4).

Group & Direct-pay Comprehensive

- Comprehensive programs incorporate both hospitalization and medical/surgical benefit components.
- Services are subject to deductibles and coinsurance. These amounts vary by the member’s type of coverage; however, the standard coinsurance amount that members are responsible for is 20 percent. In addition, members are responsible for amounts over the maximum allowable amount.
Major Medical

Major Medical is available in conjunction with basic hospitalization and medical/surgical programs. Major medical:

- Provides benefits to supplement covered expenses that exceed basic hospital and medical/surgical benefit maximums, with the exception of specified copays and deductibles for services rendered under a basic benefits plan.
- Reimburses the member directly.
- Automatically submits claims under the supplemental major medical policy when the member is enrolled in both a basic medical/surgical and supplemental major medical programs, and a claim is received under the medical/surgical policy. Therefore, it is not necessary to submit a separate claim to be considered for compensation under the member’s major medical benefit.

Small Employer Programs

Anthem also offers programs to small employers. These programs, designed for those groups who otherwise would not qualify for traditional group insurance plans, offer a similar range of services as other programs offered to larger groups.

- Small Employer Comprehensive Plan
- Small Employer Hospital/Medical - Surgical/Major Medical Plan

Small Employer Comprehensive Plan

This program is a major medical plan that incorporates hospitalization and medical benefits into a single program. The program requires:

- Deductibles and coinsurance for covered services.
- Pre-existing condition exclusions be met.
- Compliance with all utilization and clinical quality management guidelines.

Small Employer Hospital/Medical/Surgical/Major Medical

This program provides benefits for both inpatient and outpatient hospital services, medical/surgical benefits and major medical coverage. The program:

- Allows employer groups to choose stand-alone medical/surgical and major medical coverage.
- Requires that pre-existing condition exclusions be met.
- Requires compliance with all utilization and clinical quality management guidelines.

Utilization Management

Managed Benefits

Managed Benefits is a key feature of the Small Employer programs, and is an optional component for employers offering indemnity and comprehensive programs. To verify if Managed Benefits apply, please check the member’s ID card. Members with this component must follow Managed Benefits requirements to receive maximum benefits under their program.

⇒ *The physician or hospital may call on the member's behalf,* and is encouraged to do so. Proper compliance with the Managed Benefit requirements will ensure that the provider will receive direct and timely payments for services.
If the member does not comply with the Managed Benefits requirements, their benefits will be reduced in accordance with established non-compliance reductions. Benefits may also be denied for non-medically necessary days and the associated physician services.

The member or member’s representative must call the Utilization Management Department:

- **BEFORE** any scheduled inpatient admission, regardless of the reason, no later than one business day before entering the hospital.
- **AFTER** an inpatient admission for any emergency or urgent treatment. This call must be placed within 48 hours or two business days after being admitted.

Utilization Management Telephone Number:

♦ (800) 238-2227

All telephone calls required under Managed Benefits should be made during regular business hours from 8 a.m. to 5 p.m., Monday through Friday. If a telephone call cannot be made during regular business hours, the member may leave their name, identification number, telephone number and message. Their call will be returned the next business day.

Other Utilization Management Programs

Members with Managed Benefits are also subject to other Utilization Management requirements and programs. Please refer to the *Utilization Management* chapter of this manual for specific guidelines including:

- Clinical Transition Program
- Case Management
- Concurrent Review
- Prior Authorization
- Behavioral Health Treatment

Emergency Admissions Authorization

- Hospital admissions resulting from covered emergency room treatment are subject to the Managed Benefits guidelines.
- Benefits for emergency care are provided for treatment of the onset of a serious illness or injury which requires emergency medical treatment, or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is needed.
- A member copay or coinsurance may apply.
7. FEDERAL EMPLOYEES HEALTH BENEFITS

*Standard and Basic Option* Programs (FEHB)

Table of Contents

- Key Telephone Numbers.................................................................................................................. 2
- FEP Standard Option Program Highlights.................................................................................. 2
- FEP Standard Option Identification Card ................................................................................... 3
- FEP *Basic Option* Program Highlights .................................................................................... 3
- FEP *Basic Option* Identification Card ..................................................................................... 4

Utilization Management Procedures ................................................................................................. 4
  - Prior Authorization...................................................................................................................... 4
  - Emergency Admissions Authorization ..................................................................................... 5
  - Urgent Care.............................................................................................................................. 5
  - Maternity ................................................................................................................................... 5
  - Case Management.................................................................................................................... 6
  - Behavioral Health....................................................................................................................... 6
  - Vision Care............................................................................................................................... 7
  - Durable Medical Equipment (DME) ......................................................................................... 7
  - Home Nursing Care.................................................................................................................. 7
  - Hospice Care............................................................................................................................. 8
  - Physical, Occupational and Speech Therapy ........................................................................... 8
  - Chiropractic............................................................................................................................. 8
  - Smoking Cessation.................................................................................................................... 8
  - Laboratory Services................................................................................................................... 8
### Key Telephone Numbers

<table>
<thead>
<tr>
<th>Service</th>
<th>Contact Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim, Benefit, Membership and all other Inquiries</td>
<td>(800) 438-5356 (Nationwide)</td>
</tr>
<tr>
<td>Provider Call Center</td>
<td>(800) 922-3242 (toll free in CONN.) or (203) 239-3884 (local North Haven)</td>
</tr>
<tr>
<td>Prior Authorization</td>
<td></td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
</tr>
<tr>
<td>- Case Management</td>
<td>(800) 711-2225</td>
</tr>
<tr>
<td>- Home Health Care</td>
<td></td>
</tr>
<tr>
<td>- Hospice</td>
<td></td>
</tr>
<tr>
<td>- Home IV Therapy</td>
<td></td>
</tr>
<tr>
<td>Inpatient Services</td>
<td></td>
</tr>
<tr>
<td>- Inpatient Admissions</td>
<td>(800) 860-2156</td>
</tr>
<tr>
<td>Behavioral Health</td>
<td></td>
</tr>
<tr>
<td>- Standard Option and Basic Option</td>
<td>(800) 253-9875</td>
</tr>
</tbody>
</table>

For a complete list of benefits, please call: Anthem’s FEHB Program Department: (800) 438-5356 (toll free)

Or, submit your request in writing to the following address:
Anthem Blue Cross and Blue Shield
Attn: FEHB Program Department
P.O. Box 37790
Louisville, KY 40233-7790

### FEP Standard Option Program Highlights

#### Standard Option Highlights

- A *Century Preferred* type of PPO program that utilizes the Anthem *Century Preferred* PPO provider network, except for pharmacies, for which there is a separate provider panel.
- Offers direct compensation to participating physicians and other health care providers when covered services are rendered. (No benefits for chiropractic and naturopathic services, or routine vision care.)
- $250 individual, $500 family calendar-year deductible (not applicable to home and office visits).
- $15 copay for home and office services.
FEP Standard Option Identification Card

Government-Wide Service Benefit Plan PRESENTACT I ARAGON

1. **Subscriber Name**
The full name of the cardholder.

2. **Identification Number**
The number used to identify each Federal Employee Program member.

3. **Enrollment Code**
Identifies the member's specific program (104 is Standard Option, self-only)

4. **PCS**
Pharmacy Card System

5. **Effective Date of Coverage**
The date on which the member's coverage became effective.

---

**FEP Basic Option Program Highlights**

- The FEP Basic Option program provides benefits for **in-network services only**.
- There is no calendar year deductible under FEP Basic Option.
- The FEP Basic Option program utilizes Century Preferred PPO participating physicians and providers who are located in Connecticut. Behavioral health care is provided through the Century Preferred PPO provider network.
- Referrals are not required.
- Members are not required to choose a PCP.
**FEP Basic Option Identification Card**

1. **Member Name**
   The full name of the cardholder.

2. **Identification Number**
   The number used to identify each Federal Employee Program member.

3. **Enrollment Code**
   Identifies the member's specific program.

4. **Effective Date**
   Date coverage became effective.

5. **Pharmacy Information**

**Utilization Management Procedures**

The following Utilization Management information refers to both FEP Standard Option and FEP Basic Option programs unless otherwise indicated.

**Prior Authorization**

**Inpatient Admissions**

The medical necessity of a member's hospital admission must be prior authorized for the member to receive full plan benefits. The dedicated FEP medical management unit will use Milliman and Robertson criteria and Anthem internal guidelines in their review, unless there is an FEP program requirement that supersedes Anthem policy. If prior authorization is not obtained, and benefits are otherwise payable, benefits for the admission will be reduced by $500.

- **(800) 860-2156**
  Prior Authorization (inpatient admissions)
  fax: **(800) 732-8318**

For prior authorization of hospital admissions (other than behavioral health):

- **In Connecticut**: Call the telephone number above and have the following information ready.
  Provide the following information:
  - the enrollee’s name and identification number,
  - the patient’s name, birth date and phone number,
  - the reason for hospitalization,
  - proposed treatment or surgery,
  - name of the hospital or facility,
  - name and phone number of admitting physician,
  - number of planned days of confinement.

- **Out of state**: For prior authorization of admissions outside of Connecticut, call the Blue Cross & Blue Shield plan in the state where the service is rendered. See list of national Blue Cross & Blue Shield plans in Appendix D in the Appendix section of this manual.

- For **Behavioral Health** inpatient admissions, see page 7-7.
If additional days are required:
The physician or hospital must request certification for additional days. If the admission is prior authorized, but the member remains confined beyond the number of days authorized as medically necessary, the plan will not pay for charges incurred on any extra days that are not determined to be medically necessary by the plan during the claim review. Authorization for additional days must also be requested for a maternity admission for the mother if confined beyond 48 hours for vaginal delivery or 96 hours for Caesarian section as well as for a covered newborn confined beyond the mother’s discharge date.

Prior authorization is not necessary when:
- Medicare Part A, or another group health insurance policy, is the primary payer for the hospital confinement. Prior authorization is required, however, when the Medicare hospital benefits are exhausted prior to using lifetime reserve days.
- The member is confined in a hospital outside the United States and Puerto Rico.

Outpatient Services
Call the Utilization Management Department at (800) 711-2225 for prior authorization of the following services:
- Case Management
- Home Health Care
- Home IV Therapy
- Hospice
- Organ/tissue transplants; bone marrow, heart, heart-lung, liver, lung and pancreas

Clinical trials for certain organ/tissue transplants:
For prior authorization of clinical trials for bone marrow, stem cell transplants and autologous peripheral stem cell support for multiple myeloma, breast cancer, epithelial ovarian cancer, autologous bone marrow transplants (autologous stem cell support) only, call the Clinical Trials Information Unit at (800) 225-2266.

Emergency Admissions Authorization
Emergency admissions not prior authorized must be reported within two business days following the day of admission, even if the member has been discharged. Otherwise the benefits payable will be reduced by $500.

For authorization of emergency admissions:
- In Connecticut: Call (800) 860-2156
- Out of state: Call the Blue Cross & Blue Shield Plan in the state where the service is rendered.

Urgent Care
A comprehensive hospital-based urgent care network provides members access to urgent care 24 hours a day, seven days per week.

If an FEP member is admitted to the hospital from Urgent Care as an emergency admission, the admission must be authorized within two business days of the admission by calling (800) 860-2156.

Please see the “Urgent Care” section of the Utilization Management chapter of this manual for urgent care procedures and criteria.

Maternity
This coverage applies to physician or nurse midwife care for pregnancy or related conditions resulting in childbirth or miscarriage, inpatient hospital care for the mother and hospital nursery care for the baby. Nurse midwife office visit charges are not eligible for coverage.
- Prior authorization of maternity admissions for routine deliveries is not required.
Authorization of additional days is necessary for stays longer than 48 hours after a vaginal delivery and 96 hours after a cesarean section.

**Case Management**

Individual case management is a comprehensive process of review whereby an individual's catastrophic or chronic health problem is evaluated and a high quality, collaborative plan of care is developed. Individual case management is focused primarily on reducing the costs of current or future hospitalization(s) or ongoing outpatient therapies.

**Case management indicators include:**
- Potential for long-term dependence on the health care delivery system.
- Potential that appropriate care can be provided in an alternative setting in lieu of hospitalization.
- Multiple medical problems or complications.
- Prior authorization referrals, if hospitalization can be avoided.
- Potential high-cost services or treatment.
- Lack of adequate support systems for the patient or family.

For further information, contact the Case Management Department at (800) 711-2225.

**Behavioral Health**

No referral is required for members to access behavioral health services. However, if you wish to refer an FEP member for emergent or non-urgent behavioral health services, you must call Anthem at (800) 253-9875 (toll free, 24 hours a day).

Therapy should be provided by a preferred physician or a preferred qualified clinical psychologist, psychiatric nurse, clinical social worker, licensed professional counselor, marriage and family therapist, alcohol or drug counselor.

Behavioral health services for FEP members are provided by physicians and providers participating in the Anthem Blue Cross and Blue Shield PPO network. Claims for these services should be sent to the same location as med/surg claims:

Anthem Blue Cross and Blue Shield  
Attn:  FEP  
P.O. Box 37790  
Louisville, KY  40233-7790

**Outpatient Care**

**Standard Option**
- Outpatient visits are available up to 25 visits per person per calendar year for out of network providers. This maximum may be waived for services rendered by a participating provider.
- Prior Authorization/Treatment planning required prior to the ninth outpatient visit.
- In-network services are subject to a $15 copay for the visit, up to two hours per visit.
- Out-of-network services are subject to a deductible and 40 percent coinsurance. The member is also liable for any difference between the allowed charge and the total charges.

**Basic Option**
- Prior authorization/treatment planning is required prior to receiving care.
- $20 copay per visit.
Standard Option and Basic Option

- Prior authorization may be obtained by calling Anthem at (800) 253-9875. Treatment plans may be faxed to (203) 985-7306.

Inpatient Care

Prior authorization requirements outlined on page 7-4 apply to inpatient behavioral health care (subject to copay and deductible). For prior authorization of inpatient behavioral health care, call (800) 253-9875.

Inpatient Detoxification Services: Prior authorization is required for Standard Option members through FEP Medical Management at (800) 860-2156. Detoxification is considered a medical benefit under the Service Benefit Plan.

Standard Option

Lifetime maximum: Inpatient care for the treatment of alcoholism and drug abuse is limited to one treatment program (28 day maximum) per lifetime.

Vision Care

Routine vision care is not a covered service under the FEP Standard Option or Basic Option plans. Members may contact EyeMed for discounts on routine exams and eyeglasses.

Durable Medical Equipment (DME)

- Rental or purchase (if less expensive) of durable medical equipment (such as respirators and home dialysis equipment) including replacement, repair and adjustment of purchased equipment.
- Wheelchairs, hospital beds, crutches and other items determined to be durable medical equipment.
- Orthopedic braces and prosthetic appliances (such as artificial legs and pacemakers) including replacement, repair and adjustment.

FEP Standard Option:
In-Network: Coverage available with deductible and 10 percent coinsurance
Out-of-Network: Coverage available with deductible and 25 percent coinsurance, plus difference between the allowed charge and the billed charge.

FEP Basic Option: Coverage available with 30 percent copay. Eligible for coverage only when purchased through a preferred provider.

Home Nursing Care

Prior authorization required. (800) 711-2225. Care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) is eligible for coverage when the care is ordered by a physician. Home nursing care is available for two hours per day up to 25 visits per calendar year, as follows:

FEP Standard Option: Subject to deductible and coinsurance
- In-network: Subject to deductible and 10 percent coinsurance.
- Out-of-network: Subject to deductible and 25 percent coinsurance plus the difference between MAA and billed amount.

FEP Basic Option: $20 copay per visit
Hospice Care

Prior authorization required. (800) 711-2225. Home hospice care is eligible for coverage in full as follows:

- **FEP Standard Option and Basic Option:** unlimited days

Physical, Occupational and Speech Therapy

Coverage is available for physical, occupational and speech therapy when rendered and billed by a physical, occupational or speech therapist who is licensed or meets the requirements of Anthem, by a physician rendered on an outpatient basis, or by an outpatient facility.

**FEP Standard Option:**

Physical Therapy:

- 75 visits per person per calendar year in or out-of-network
- In-network: $15 copay per visit.
- Out-of-network: Subject to deductible and 25 percent coinsurance. Member liable for difference between allowed charge and total charges.

**FEP Basic Option:**

- Physical/Occupational/Speech Therapy: $20 copay for primary care physicians; $30 copay for specialists.
- 50 visits per person per calendar year.

Chiropractic

**FEP Standard Option:** Not a covered service under the FEP Standard Option plan.

**FEP Basic Option:** $20 copay. Coverage includes up to 20 spinal manipulations and an initial set of x-rays per year by a participating chiropractor.

Smoking Cessation

Smoking cessation is eligible for coverage when services are rendered by a preferred provider. If an office visit is charged, the member will be responsible for an office visit copay.

Laboratory Services

- **FEP Standard Option:** Refer to your provider directory for list of participating laboratories.

- **FEP Basic Option – Quest Diagnostic:** In-network outpatient clinical laboratory and pathology services for FEP Basic Option are provided by Quest Diagnostic, Clinical Laboratory Partners LLC or a consortium of more than 30 participating hospital-affiliated laboratories or pathology groups. Under this arrangement, participating physicians and health care professionals are required to refer FEP Basic Option members, or send their specimens, to one of these designated laboratories for service.

  For Quest Diagnostic lab sites call: **(800) 225-7483**.

**Under FEP Basic Option only:** The following services are eligible for coverage when performed in the physician’s office:

<table>
<thead>
<tr>
<th>Service Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81000</td>
<td>Urinalysis, by dip stick or tablet reagent; non-automated, with microscopy</td>
</tr>
<tr>
<td>81002</td>
<td>Urinalysis, non-automated, without microscopy</td>
</tr>
<tr>
<td>81003</td>
<td>Urinalysis, automated without microscopy</td>
</tr>
</tbody>
</table>

(continued)
### Laboratory Services Eligible for Coverage when Performed in the Physician’s Office continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>81005</td>
<td>Urinalysis, qualitative or semi-quantitative, except immunoassay</td>
</tr>
<tr>
<td>81007</td>
<td>Urinalysis; bacteriuria screen, except by culture or dipstick</td>
</tr>
<tr>
<td>81025</td>
<td>Urine preg test, by visual color comparison methods</td>
</tr>
<tr>
<td>82120</td>
<td>Amines, vaginal fluid, qualitative</td>
</tr>
<tr>
<td>82270</td>
<td>Blood, occult, by peroxidase activity (eg, guaiac); feces, 1-3 simultaneous determinations</td>
</tr>
<tr>
<td>82803</td>
<td>Gasses, blood, any combination of pH, pCO2, pO2, CO2, HCO3 (including calculated O2 saturation) <strong>This procedure approved for Pulmonologists ONLY</strong></td>
</tr>
<tr>
<td>82947</td>
<td>Glucose, quantitative, blood (except reagent strip)</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose, blood, reagent strip</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose, blood by glucose monitoring device(s) cleared by the FDA specifically for home use</td>
</tr>
<tr>
<td>83036</td>
<td>Hemoglobin; glycerated</td>
</tr>
<tr>
<td>83986</td>
<td>PH, body fluid, except blood</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding Time</td>
</tr>
<tr>
<td>85007</td>
<td>Blood Count; manual differential WBC count (includes RBC morphology and platelet estimation)</td>
</tr>
<tr>
<td>85013</td>
<td>Hematocrit, spun microhematocrit</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit, other than spun hematocrit</td>
</tr>
<tr>
<td>85018</td>
<td>Hemoglobin</td>
</tr>
<tr>
<td>85023</td>
<td>Blood count; hemoglobin and platelet count, automated, and manual differential WBC count (CBC)</td>
</tr>
<tr>
<td>85024</td>
<td>Blood count; hemoglobin and platelet count, automated, and automated partial differential WBC count (CBC)</td>
</tr>
<tr>
<td>85025</td>
<td>Blood count; hemoglobin and platelet count, automated, and automated complete differential WBC count (CBC)</td>
</tr>
<tr>
<td>85095</td>
<td>Bone marrow; aspiration only</td>
</tr>
<tr>
<td>85097</td>
<td>Bone marrow; smear interpretation only, with or without differential cell count</td>
</tr>
<tr>
<td>85102</td>
<td>Bone marrow biopsy, needle or trocar</td>
</tr>
<tr>
<td>86403</td>
<td>Particle agglutination; screen, each antibody</td>
</tr>
<tr>
<td>86580</td>
<td>Skin Test; Tuberculosis, intradermal</td>
</tr>
<tr>
<td>86585</td>
<td>Skin Test; Tuberculosis, tine test</td>
</tr>
<tr>
<td>87081</td>
<td>Culture, presumptive, pathogenic organisms, screening only</td>
</tr>
<tr>
<td>87210</td>
<td>Smear, primary source, with interpretation; wet mount for infectious agents (eg, saline, India ink, KOH preps)</td>
</tr>
<tr>
<td>87220</td>
<td>Tissue examination by KOH slide of samples from skin, hair, or nails for fungi or ectoparasite ova or mites (eg, scabies)</td>
</tr>
<tr>
<td>87430</td>
<td>Infectious agent antigen detection by enzyme immunoassay technique, qualitative or semiquantitative, multiple step method; Streptococcus, Group A</td>
</tr>
<tr>
<td>87880</td>
<td>Infectious agent detection by immunoassay with direct optical observation; Streptococcus, group A</td>
</tr>
<tr>
<td>88170</td>
<td>Fine needle aspiration; superficial tissue (e.g., thyroid, breast, prostate)</td>
</tr>
<tr>
<td>89060</td>
<td>Crystal identification by light microscopy with or without polarizing lens analysis, any body fluid (except urine)</td>
</tr>
<tr>
<td>89300</td>
<td>Semen analysis; presence and/or motility of sperm including Huhner test (post coital)</td>
</tr>
<tr>
<td>89310</td>
<td>Semen analysis; motility and count</td>
</tr>
<tr>
<td>89320</td>
<td>Semen analysis; complete (volume, count, motility and differential)</td>
</tr>
<tr>
<td>89321</td>
<td>Semen analysis, presence and/or motility of sperm</td>
</tr>
<tr>
<td>89330</td>
<td>Sperm evaluation; cervical mucus penetration test, with or without spinbarkeit test</td>
</tr>
</tbody>
</table>
# 8. MEDICARE SUPPLEMENTAL (MEDIGAP) PROGRAMS

## Table of Contents

- Key Telephone Numbers ................................................................. 2
- Medigap Programs ........................................................................... 2
- Medicare Part A Supplement .......................................................... 2
  - High Option Program Highlights ................................................. 2
  - Low Option Program Highlights ............................................... 3
  - High and Low Option Alternative .............................................. 3
- Medicare Part B Supplement .......................................................... 3
  - Plan 81, 82 and 83 Program Highlights .................................... 3
  - Sample Medicare Part B Supplemental Identification Card ........ 3
- Comprehensive Supplemental Programs ........................................ 4
  - Plans A, B, C, D, F, H, J .............................................................. 4
  - Sample Member Identification Card ......................................... 4
Medigap Programs

To bridge the gap between Medicare’s health insurance benefits package and the cost of health care, Anthem Blue Cross and Blue Shield offers Medicare Supplemental programs for members. They are:

- **Medicare Part A supplement**
  - High Option (and High Option Alternative)
  - Low Option (and Low Option Alternative)

- **Medicare Part B supplement**
  - Plan 81
  - Plan 82
  - Plan 83

- **Comprehensive supplemental programs**
  - Plan A
  - Plan B
  - Plan C
  - Plan D
  - Plan F
  - Plan H
  - Plan J

- **Former CHCP Programs**
  - BlueCare Care Plus
  - Medigap Plan J

**Medicare Part A Supplement**

**High and Low Option Programs (and Alternatives)**

**High Option Program Highlights**

- The 65 High Option plan is designed to supplement Medicare Part A for hospital expenses. The program qualifies as a Medicare Supplemental program under State of Connecticut standards.
- The program includes benefits for services covered by Medicare Part A, such as hospital, skilled nursing, emergency room, outpatient hospital services and home health care.
- Prescription drug benefits are provided following an inpatient admission or an outpatient surgery in a hospital.
Low Option Program Highlights

- The 65 Low Option plan is designed to supplement Medicare Part A for hospital expenses. The program qualifies as a Medicare Supplemental program under State of Connecticut standards.
- The program includes benefits for services covered by Medicare Part A, such as hospital, skilled nursing, emergency room and outpatient hospital services.
- A per-admission inpatient deductible is applicable and members are responsible for coinsurance when specific services are received.
- Prescription drug benefits are provided following an inpatient admission.

High and Low Option Alternative

Anthem offers High and Low Option Alternatives for those who do not require prescription drug coverage. With the exception of prescription coverage, benefits under these plans are identical to those provided by the High and Low Option programs.

Medicare Part B Supplement

Plan 81, 82 and 83 Program Highlights

- Anthem Plan 81, 82 and 83 are designed to supplement Medicare Part B for medical/surgical expenses.
- The programs provide payment for the balance of Medicare approved services after the annual Medicare deductible has been met. Plan 81 and 83 also provide payment for the annual deductible.

Sample Medicare Part B Supplemental Identification Card

Medical Surgical Field

Will indicate BS651 for Plan 81, BS652 for Plan 82 or BS653 for Plan 83.

Hospital Field

Will indicate BC65H for High Option benefits and BC65L for Low Option benefits.
Comprehensive Supplemental Programs

Plans A, B, C, D, F, H, J

In accordance with federal law requiring the standardization of all Medigap plans, Anthem offers seven comprehensive, supplemental programs to members enrolled in both Medicare Parts A and B. Each of the plans provides a "core" set of benefits designed to supplement those provided by Medicare.

Sample Member Identification Card

![Sample Member Identification Card](image)
9. National Accounts

Table of Contents

Key Telephone Numbers........................................................................................................................ 2
General Description................................................................................................................................. 2
Benefit Programs................................................................................................................................... 3
Compensation ......................................................................................................................................... 3
Key Telephone Numbers

<table>
<thead>
<tr>
<th>Claims, Benefit and Membership Inquires</th>
<th>The member’s ID card will contain the phone number that you can call to verify eligibility, check covered benefits, or determine the status of a claim.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Or for assistance you may contact:</td>
<td></td>
</tr>
<tr>
<td>National Accounts Division</td>
<td>(800) 224-5105 or (800) 676-BLUE (2583)</td>
</tr>
<tr>
<td>Provider Call Center</td>
<td>(800) 922-3242 (toll free in Connecticut), or (203) 239-3884 (local North Haven).</td>
</tr>
<tr>
<td>Utilization Management</td>
<td>The member’s ID card will contain a phone number to contact regarding UM procedures and guidelines if required by the member’s benefit plan.</td>
</tr>
</tbody>
</table>

National Accounts

General Description

**PPO USA, National PPO and National Accounts**

Anthem Blue Cross and Blue Shield partners with other Blue Cross and Blue Shield plans throughout the country to provide benefit programs to large employers who have employees working and residing in different states. Anthem’s participation in these programs can be as a Control Plan or a Participating Plan, as follows:

**Control Plan:**
- The plan that underwrites the account and may perform all or part of the claims processing services, as well as customer service and institutional relations functions.
- Generally serves the geographic area in which the corporate headquarters of a national account is based.
- As an example, Anthem is the Control Plan for national accounts headquartered in Connecticut.

**Participating (Par) Plan:**
- Contacted by the Control Plan to coordinate services rendered in the participating plan’s state.
- Generally, the Par plan serves an area in which a portion of the national account members are employed, while the corporate headquarters are located in another state and serviced by a different Blue Cross and Blue Shield plan.
- While the Par plan provides health care services through local providers, it may or may not perform complete claims processing and/or customer service depending on the arrangement with the control plan.
- The member’s identification card will provide you with claims filing and customer service information.
Benefit Programs

National account members will have the product names PPO USA, National PPO or National Accounts printed on their ID card. PPO USA and National PPO products indicate the member is from a fully insured group or an ASO group with under 1,000 members.

Under our national account products we offer a variety of benefit programs including HMO, point-of-service (POS) and preferred provider organization (PPO) programs, as well as traditional Anthem plans. These programs include:

- BlueCare Health Plan programs
- HMO Blue New England and BlueChoice New England (New England Health Plans programs)
- Century Preferred and Century Preferred Comp plans
- Century 90

*Always Call to Verify Coverage and Eligibility!*

National account products frequently include “non-standard” benefits. That is, the benefits of the plan may differ from our standard benefits in order to match the coverage offered by the control plan or to meet the needs of a large employer. Therefore, it's important for you to verify coverage and eligibility by calling the number on the member’s ID card or by contacting the Anthem National Account Division at (800) 327-9232 (toll-free nationwide) or (800) 233-6183 (in Conn.).

Claim Submission

*Medical/Surgical Claims:*

When Connecticut is the Control Plan

Anthem Blue Cross and Blue Shield
P.O. Box 726
North Haven, CT  06473

When Connecticut is the Participating Plan

Anthem Blue Cross and Blue Shield
P.O. Box 718
North Haven, CT  06473

Compensation

- You will receive compensation for covered services rendered to national account members directly from Anthem 1) when Anthem is the Control Plan, or 2) if the Control Plan has arranged for Anthem as the Par Plan to process claims.

- Claims appropriately processed by Anthem for covered services rendered to a national account member are subject to all Anthem contract terms and conditions. Because compensation is made directly to you, please do not request payment from these members at the time of service (with the exception of copays, deductibles and coinsurance).

- If a claim is processed by the Control Plan, it is subject to all Anthem contract terms and conditions. However, the Control Plan may have its own claim processing requirements. The provider should contact the control plan directly to confirm Control Plan requirements.
# 10. THE BLUECARD® PROGRAM

## Table of Contents

- Key Telephone Numbers ........................................................................................................ 2
- BlueCard Program Overview .................................................................................................. 2
- How Does the BlueCard® Program Work? ........................................................................... 3
  - How to Identify BlueCard Members ................................................................................ 3
  - Suitcase Logos On Member ID Cards .............................................................................. 4
  - How to Identify BlueCard POS Members ........................................................................ 4
  - How to Identify International Members ......................................................................... 5
  - How to Verify Membership and Coverage ....................................................................... 5
  - How to Obtain Utilization Review .................................................................................. 6
  - Handling Border Claim Submissions for BlueCard PPO, HMO and Traditional ............. 6
  - International Claims ........................................................................................................ 7
  - Indirect, Support or Remote Providers ........................................................................... 7
  - Exceptions to BlueCard Claims Submissions ................................................................. 7
  - Coordination of Benefits (COB) Claims .......................................................................... 8
  - Payment for BlueCard® Claims ..................................................................................... 9
  - Who to Contact with Inquiries ....................................................................................... 9
- What Products Are Included in the BlueCard® Program? ................................................... 10
- Frequently Asked Questions .............................................................................................. 11
- BlueCard® Program Quick Tips .......................................................................................... 18
### BlueCard Program Overview

**Definition**

The BlueCard Program enables members obtaining health care services while traveling or living in another plan's service area to receive the benefits of the Blue Cross and Blue Shield (BCBS) plan listed on their insurance card and to access local plan's provider networks and savings. Variations in provider contractual arrangements may impact the delivery of benefits. Through a single electronic network for claims processing and reimbursement, the BCBS plan listed on the member's ID card handles eligibility and benefit determination and gains access to health care providers participating in the local BCBS plan's network.

More than 85 percent of all doctors and hospitals throughout the United States contract with BCBS Plans. Outside of the United States, members have access to doctors and hospitals worldwide. Not only can members take advantage of savings that the local Blue plan has negotiated with providers, members do not have to complete a claim form or pay up front for health care services, except for out-of-pocket expenses, such as deductibles, co-payments and coinsurance.

**BlueCard® Program Advantages**

The BlueCard Program allows you to submit claims for members from other BCBS Plans including international BCBS Plans, directly to Anthem. Anthem will be your one point of contact for most of your claims-related questions.

**Claims and Products Included in the BlueCard® Program**

The BlueCard Program applies to all inpatient, outpatient, and professional claims.

Traditional, PPO, POS, and HMO products are included in the BlueCard Program. The following products are *optional* under the BlueCard Program:

- Stand-alone dental and prescription drugs
- Stand-alone vision and hearing
- Medicare supplemental

**Products Excluded from the BlueCard® Program**

Medicare+Choice is excluded from the BlueCard Program. You must file Medicare+Choice claims with the member’s BCBS Plan.

**Accounts Exempt from the BlueCard® Program**

Claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program. Please follow your FEP billing guidelines.
How Does the BlueCard® Program Work?

How to Identify BlueCard Members

When members from other Blue Cross and Blue Shield Plans arrive at your office or facility, be sure to ask them for their current Blue Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, a blank suitcase logo, and, for eligible PPO members, the “PPO in a suitcase” logo.

Alpha Prefix
The three-character alpha prefix at the beginning of the member’s identification number is the key element used to identify and correctly route out-of-area claims. The alpha prefix identifies the Blue Cross Blue Shield Plan or national account to which the member belongs. It is critical for confirming a patient’s membership and coverage.

There are two types of alpha prefixes: Plan-specific and account-specific.

1. **Plan-specific alpha prefixes starting with X, Y, Z or Q are assigned to every Plan except those identified in #2 below.** The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.
   - First character   X, Y, Z or Q
   - Second character  A-Z
   - Third character   A-Z

2. **Account-specific prefixes starting with letters other than X, Y, Z or Q are assigned to centrally processed national accounts.** National accounts are employer groups that have offices or branches in more than one area, but offer uniform benefits coverage to all of their employees. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

**Identification cards with no alpha prefix:** Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for how to file these claims.

**It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage.** We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. **Do not make up alpha prefixes.**

If you are not sure about your participation status (traditional, PPO, POS, or HMO), call Anthem Provider Call Center:
- Professional Providers:  (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven)
- Institutional Providers:  (800) 345-2227 (in Conn.), or (800) 545-0948 ext. 2735 (out of state).
Suitcase Logos On Member ID Cards

Blank Suitcase Logo

A blank suitcase logo on a member’s ID card means that the patient has Blue Cross Blue Shield traditional, POS, or HMO benefits delivered through the BlueCard Program.

The blank suitcase logo may appear anywhere on the front of the ID card.

“PPO in a Suitcase” Logo

You’ll immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card. BlueCard PPO members are Blue Cross and Blue Shield members whose PPO benefits are delivered through the BlueCard Program. It is important to remember that not every member who belongs to an out-of-state PPO plan is eligible for BlueCard PPO coverage. Only those PPO members with the “PPO in a suitcase” logo on their membership cards are BlueCard PPO members. BlueCard PPO members traveling or living outside of their Blue Plan’s area receive the PPO level of benefits when they obtain services from designated BlueCard PPO providers.

The "PPO in a suitcase" logo may appear anywhere on the front of the card.

How to Identify BlueCard POS Members

The BlueCard POS program is for members who reside outside their Blue Plan’s service area. However, unlike other BlueCard programs, BlueCard POS members are enrolled in Anthem’s network and primary care physician (PCP) panels. You can recognize BlueCard POS members who are enrolled Anthem’s network through the member ID card, as you do for all other BlueCard members. The ID cards will include (1) a local network identifier and (2) the three-character alpha prefix preceding the member’s ID number. The POS ID card also includes the blank suitcase logo (see next page for sample ID card).

Continued
How to Identify International Members

Occasionally, you may see identification cards from foreign Blue Cross and Blue Shield Plan members. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic Blue Cross and Blue Shield Plan members.

How to Verify Membership and Coverage

Once you've identified the alpha prefix, call BlueCard Eligibility to verify the patient's eligibility and coverage.

1. Have the member's ID card ready when calling.
2. Dial (800) 676-BLUE.

Operators are available to assist you weekdays during regular business hours (7 a.m. – 10 p.m. EST). They will ask for the alpha prefix shown on the patient's ID card and will connect you directly to the appropriate membership and coverage unit at the member's Blue Cross Blue Shield Plan. If you call after hours, you will get a recorded message stating the business hours. Keep in mind BCBS Plans are located throughout the country and may operate on a different time schedule than Anthem. It is possible you will be transferred to a voice response system linked to customer enrollment and benefits or you may need to call back at a later time.
Home Plan vs. Host Plan

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

**Host Plan** -- The area in which a member from a Home Plan account selects a primary care physician is responsible for provider and medical management services for the member.

How to Obtain Utilization Review

You should remind patients from other Blue Plans that they are responsible for obtaining prior authorization for their services from their Blue Cross and Blue Shield **Home Plan**. You may also choose to contact the member’s Plan on behalf of the member by calling the number on the back of the member’s ID card. Or, if you choose to do so, you can ask to be transferred to the utilization review area when you call BlueCard **Eligibility (1.800.676.BLUE)** for membership and coverage information.

Where and How to Submit BlueCard® Program Claims

You should always submit BlueCard claims to:

Anthem Blue Cross and Blue Shield  
P.O. Box 533  
North Haven, CT  06473

Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. **Do not make up alpha prefixes.** Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once Anthem receives a claim, it will electronically route the claim to the member’s Blue Cross and Blue Shield Plan. The member’s Plan then processes the claim and approves payment, and Anthem will pay you according to your contracted Connecticut compensation.

If you are a non-PPO (traditional) provider and are presented with an identification card with the “PPO in a suitcase” logo on it, you should still accept the card and file with your local Blue Cross and Blue Shield Plan. You will still be given the appropriate traditional pricing.

Handling Border Claim Submissions for BlueCard PPO, HMO and Traditional

<table>
<thead>
<tr>
<th>Scenario</th>
<th>Where To Submit Claims</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider is participating with two states and has offices in both.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1a. Patient is a Blue Plan member, but not member of either states Blue Plan.</td>
<td>Submit claim to state where services were rendered.</td>
<td>Provider is participating in both NY and CT and has offices in both states. Member is a Blue Plan member in NJ, but visits the CT office. Provider should submit the claims to CT plan.</td>
</tr>
</tbody>
</table>

(continued)
Border Claim Submissions Continued

<table>
<thead>
<tr>
<th>1b. Provider is participating in the state where the patient is a member.</th>
<th>Submit claim to state where both are participating.</th>
<th>Provider is participating in RI. Patient is a BCBS Plan member in RI, but had services in CT. Provider should submit claim to RI plan.</th>
</tr>
</thead>
</table>

2. Doctor participates with two states, only has an office in one state.

<table>
<thead>
<tr>
<th>2a. Patient is a Blue Plan member in one of the states the provider participates in.</th>
<th>Submit claim to the Plan in the state where both the patient is a member and the provider is participating.</th>
<th>Provider participates in RI and CT and has one office located in CT. Patient is a BCBS Plan member in RI who visits CT office. Provider should submit claim to RI plan.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2b. Patient is Blue Plan member, but is not a member in either state the provider participates in.</td>
<td>The provider can submit to either state where they are participating. But it is recommended that the provider submit to the state where their office is located</td>
<td>Provider participating in both RI and CT, with one office in CT. Patient is not a member in either states’ BCBS Plans. Provider can submit claim to either plan, CT plan recommended.</td>
</tr>
</tbody>
</table>

International Claims

The claim submission process for international BCBS Plan members is the same as for domestic BCBS Plan members. You should submit the claim directly to Anthem.

Indirect, Support or Remote Providers

If you are a health care provider that offers products, materials, informational reports and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support, or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.

If you are an indirect provider for members from multiple BCBS Plans, follow these claim filing rules:

- If you have a contract with the member’s Plan, file with that Plan.
- If you normally send claims to the direct provider of care, follow normal procedures.
- If you do not normally send claims to the direct provider of care and you do not have a contract with the member’s Plan, file with your local BCBS Plan.

Exceptions to BlueCard Claims Submissions

Occasionally, situations may arise in which the member’s home plan may request or require you to file the claim directly with them. We call this DealDirect. Here are some of those situations:

- You contract the member’s BCBS Plan (for example, in contiguous county or overlapping service area situations).
- The ID card does not include an alpha prefix.
- A claim is returned to you from Anthem because no alpha prefix was included on the original claim that was submitted.
- A temporary processing issue with Anthem, the member’s BCBS Plan or both prevents completion of the claim through the BlueCard Program.
Claims for Accounts Exempt from the BlueCard Program

When a member belongs to an account that is exempt from the BlueCard Program, Anthem will forward your claims to the member’s BCBS Plan. That means you will no longer need to send paper claims directly to the member’s BCBS Plan. Instead, you will submit these claims to Anthem in Connecticut. You may, if you wish, submit the claim directly to the member’s home plan (DealDirect). However, you will continue to submit Medicare supplemental (Medigap) under your current process (see below).

How the Forwarding Process Works

- You will submit these claims with alpha prefixes exempt from BlueCard directly to Anthem, which will forward the claims to the member’s Plan for you.
  - It is important for you to correctly capture on the claim the member’s complete identification number, including the three-character alpha prefix at the beginning. If you don’t include this information, Anthem may return the claim to you and this will delay claims resolution and your payment.
  - It is also important for you to call BlueCard Eligibility at (800) 676.BLUE to verify the member’s eligibility and coverage.
- If the member’s claim is exempt from the BlueCard Program, Anthem will inform you that the claim is being forwarded to the member’s Plan.
  - In most cases, the member’s BCBS Plan will contact you for additional information. For example, if the member’s Plan can’t identify the member, the member’s BCBS Plan may return the claim to you just as it would currently with a paper claim. If this happens, you will need to check and verify the billing information and resubmit the claim with additional/corrected information to Anthem.

Coordination of Benefits (COB) Claims

Coordination of benefits (COB) refers to how we make sure people receive full benefits and prevent double payment for services when a member has coverage from two or more sources. The member’s contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.

If after calling (800) 676-BLUE (2583) or through other means you discover the member has a COB provision in their benefit plan, and Anthem is the primary payer, submit the claim along with information regarding COB to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

If you do not include the COB information with the claim, the member’s BCBS Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

Medicare Supplemental (Medigap) Claims

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number (HICN); the patient’s complete BCBS Plan identification number, including the three-character alpha prefix; and the BCBS name as it appears on the patient’s ID card, for supplemental insurance. This will ensure cross-over claims are forwarded appropriately.

Do not file with Anthem and Medicare simultaneously. Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer.
**Cross-over Claims**: If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 printed on it, which states, “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

**Claim Not Crossed Over**: If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim as you do. Anthem or the member’s BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.

**Payment for BlueCard® Claims**

If you haven’t received payment, do not resubmit the claim. If you do, the home plan will deny the claim as a duplicate. You will also confuse the member because he or she will receive another EOB and will need to call customer service. Please understand that timing for claims processing varies at each BCBS Plan. Anthem’s standard time for claims processing is 5-10 days.

The next time you don’t receive your payment or a response regarding your payment, please call our dedicated BlueCard Unit at (800) 895-9915 (toll free in Conn.) or (203) 499-6238 (local North Haven), or visit our Web site at anthem.com.

In some cases, a member’s BCBS Plan may suspend a claim because medical review or additional information is necessary. When resolution of claim suspensions requires additional information from you, Anthem may either ask you for the information or give the member’s Plan permission to contact you directly.

**Who to Contact with Inquiries**

**Who to Contact with Claim Questions**

Claims Inquiries

(800) 895-9915 (toll free in Conn.)

or

(203) 499-6238 (local North Haven)

**How to Handle Calls from Members and Others With Claims Questions**

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

**Where to Find More Information About the BlueCard® Program**

For more information about the BlueCard Program, call Anthem’s dedicated BlueCard Unit at (800) 895-9915 or (203) 499-6238 (local North Haven), or visit the Blue Cross and Blue Shield Association’s Web site at www.bcbs.com.
## What Products Are Included in the BlueCard® Program?

### Background

Currently four types of products are administered through the BlueCard Program: BlueCard Traditional, BlueCard PPO, BlueCard POS, and HMO.

### BlueCard® Traditional

(Antibeth administers and reimburses claims for BlueCard Traditional members the same as BlueCard PPO members)

A national program that offers members traveling or living outside of their BCBS Plan’s area the traditional, or indemnity level of benefits when they obtain services from a physician or hospital outside of their BCBS Plan’s service area.

### BlueCard® PPO

A national program that offers members traveling or living outside of their BCBS Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

### BlueCard® POS

Similar to BlueCard Traditional and BlueCard PPO, the BlueCard POS program is for members who reside outside their BCBS Plan’s service area. However, unlike other BlueCard programs, BlueCard POS members are actually enrolled in the Anthem BlueCare Health Plan network and primary care physician (PCP) panels. Therefore, you should treat these members as you treat any other BlueCare POS member, applying the same referral practices and network protocols.

### HMO Patients Serviced Through the BlueCard® Program

(Anthebeth administers and reimburses claims for BlueCard HMO members the same as BlueCard PPO members)

In the coming months, you may soon be seeing a growing number of BCBS HMO members affiliated with other BCBS Plans who will be seeking care at your office or facility. You should handle claims for these members the same way as you do Anthem members and BCBS traditional, PPO and POS patients from other BCBS Plans—by submitting them through the BlueCard Program.
Frequently Asked Questions

1. What Is the BlueCard® Program?

The BlueCard Program is a national program that enables members obtaining healthcare services while traveling or living in another BCBS Plan’s area to receive all the same benefits of their contracting BCBS Plan and access to providers and savings. The program links participating health care providers and the independent BCBS Plans across the country and around the world through a single electronic network for claims processing and reimbursement.

15. What products are included in the BlueCard® Program?

Currently four types of products are administered through the BlueCard Program: BlueCard Traditional, BlueCard PPO, BlueCard POS, and HMO. The following products are optional under the BlueCard Program.

- Stand-alone dental and prescription drugs
- Stand-alone vision and hearing
- Medicare supplemental

3. What products and accounts are excluded from the BlueCard® Program?

Medicare+Choice is excluded from the BlueCard Program. You must file Medicare+Choice claims with the member’s BCBS Plan. In addition, claims for the Federal Employee Program (FEP) are exempt from the BlueCard Program. Please follow your FEP billing guidelines.

4. What is the BlueCard® Traditional Program?

A national program that offers members traveling or living outside of their BCBS Plan’s area the traditional, or indemnity level of benefits when they obtain services from a physician or hospital outside of their BCBS Plan’s service area. In Connecticut, members with the BlueCard traditional program are served by the Century 90 network.

5. What is the BlueCard® PPO Program?

A national program that offers members traveling or living outside of their BCBS Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.

6. What is the BlueCard® POS Program?

Similar to BlueCard Traditional and BlueCard PPO, the BlueCard POS program is for members who reside outside their Blue Cross Blue Shield Plan’s service area. However, unlike other BlueCard programs, BlueCard POS members are actually enrolled in the Anthem network and primary care physician (PCP) panels. Therefore, you should treat these members as you treat any other Anthem POS member, applying the same referral practices and network protocols.

7. Are HMO patients serviced through the BlueCard® Program?

Occasionally, BCBS HMO members affiliated with other BCBS Plans will seek care at your office or facility. You should handle claims for these members the same way as you do Anthem members and BCBS traditional, PPO and POS patients from other BCBS Plans—by submitting them through the BlueCard Program. In Connecticut, members with a BlueCard HMO program are served by the Century 90 network.
8. How do I identify BlueCard® members?

When members from other BCBS Plans arrive at your office or facility, be sure to ask them for their current BCBS Plan membership identification card. The main identifiers for BlueCard members are the alpha prefix, a blank suitcase logo, and, for eligible PPO members, the “PPO in a suitcase” logo.

9. What is an “alpha prefix?”

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

10. What are the various types of alpha prefixes?

There are two types of alpha prefixes: Plan-specific and account-specific.

**Plan-specific alpha prefixes** are assigned to every Plan and start with X, Y, Z, or Q. The first two positions indicate the Plan to which the member belongs while the third position identifies the product in which the member is enrolled.

- First character: X, Y, Z, or Q
- Second character: A-Z
- Third character: A-Z

**Account-specific prefixes** start with letters other than X, Y, Z, or Q, and are assigned to centrally processed national accounts. National accounts are employer groups that have offices or branches in more than one area, but offer uniform benefits coverage to all of their employees. Typically, a national account alpha prefix will relate to the name of the group. All three positions are used to identify the national account.

11. What do I do if a member has an identification card without an alpha prefix?

Some identification cards may not have an alpha prefix. This may indicate that the claims are handled outside the BlueCard Program. Please look for instructions or a telephone number on the back of the member’s ID card for how to file these claims. **It is very important to capture all ID card data at the time of service. This is critical for verifying membership and coverage.** We suggest that you make copies of the front and back of the ID card and pass this key information on to your billing staff. **Do not make up alpha prefixes.**

12. How do I determine a member’s participation status (traditional, PPO, POS, or HMO)?

To determine a member’s participation status, check the ID card logo.

A blank suitcase logo on a member’s ID card means that the patient has BCBS traditional, POS, or HMO benefits delivered through the BlueCard Program.

You’ll immediately recognize BlueCard PPO members by the special “PPO in a suitcase” logo on their membership card. BlueCard PPO members are BCBS members whose PPO benefits are delivered through the BlueCard Program. **It is important to remember that not every member who belongs to an out-of-state PPO plan is eligible for BlueCard PPO coverage. Only those PPO members with the “PPO in a suitcase” logo on their membership cards are BlueCard PPO members.** BlueCard PPO members traveling or living outside of their BCBS Plan’s area receive the PPO level of benefits when they obtain services from designated BlueCard PPO providers.
13. How do I identify BlueCard® POS members?

The BlueCard POS program is for members who reside outside their BCBS Plan’s service area. However, unlike other BlueCard programs, BlueCard POS members are enrolled in Anthem’s HMO network and primary care physician (PCP) panels. You can recognize BlueCard POS members who are enrolled in Anthem’s HMO network through the member ID card, as you do for all other BlueCard members.

14. How do I identify international members?

Occasionally, you may see identification cards from foreign BCBS Plan members. These ID cards will also contain three-character alpha prefixes. Please treat these members the same as domestic BCBS Plan members.

15. How do I verify membership and coverage?

Once you’ve identified the alpha prefix, call BlueCard Eligibility to verify the patient’s eligibility and coverage.
• Have the member’s ID card ready when calling.
• Dial (800) 676-BLUE.

16. How do I obtain utilization review?

You should remind patients from other BCBS Plans that they are responsible for obtaining prior authorization for their services from their BCBS Plan. You may also choose to contact the member’s Plan on behalf of the member. If you choose to do so, you can ask to be transferred to the utilization review area when you call BlueCard Eligibility, (800) 676.BLUE, for membership and coverage information.

17. Where and how do I submit BlueCard® Program claims?

You should always submit BlueCard claims electronically, or via hardcopy to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

Be sure to include the member’s complete identification number when you submit the claim. The complete identification number includes the three-character alpha prefix. Do not make up alpha prefixes. Incorrect or missing alpha prefixes and member identification numbers delay claims processing.

Once Anthem receives a claim, it will electronically route the claim to the member’s BCBS Plan. The member’s Plan then processes the claim and approves payment, and Anthem will pay you.

18. How do I submit international claims?

The claim submission process for international BCBS Plan members is the same as for domestic BCBS Plan members. You should submit the claim directly to Anthem.

19. How do I submit claims if I am an indirect, support, or remote provider?

If you are a health care provider that offers products, materials, informational reports, and remote analyses or services, and are not present in the same physical location as a patient, you are considered an indirect, support or remote provider. Examples include, but are not limited to, prosthesis manufacturers, durable medical equipment suppliers, independent or chain laboratories, or telemedicine providers.
If you are an indirect provider for members from multiple BCBS Plans, follow these claim filing rules:

- If you have a contract with the member’s Plan, file with that Plan.
- If you normally send claims to the direct provider of care, follow normal procedures.
- If you do not normally send claims to the direct provider of care and you do not have a contract with the member’s Plan, file with your local BCBS Plan.

**20. What are the exceptions to BlueCard claims submissions?**

Occasionally, situations may arise in which the member’s home plan may request or require you to file the claim directly with them. We call this **DealDirect**. Here are some of those situations:

- You contract with the member’s BCBS Plan (for example, in contiguous county or overlapping service area situations).
- The ID card does not include an alpha prefix.
- A claim is returned to you from Anthem because no alpha prefix was included on the original claim that was submitted.
- A temporary processing issue with Anthem, the member’s BCBS Plan or both prevents completion of the claim through the BlueCard Program.

**21. How do I handle claims for accounts exempt from the BlueCard Program?**

When a member belongs to an account that is exempt from the BlueCard Program, Anthem will forward your claims to the member’s BCBS Plan. That means you will no longer need to send paper claims directly to the member’s BCBS Plan. Instead, you will submit these claims to Anthem. You may, if you wish, submit the claim directly to the member’s home plan (DealDirect). However, you will continue to submit Medicare supplemental (Medigap) under your current process (see below).

**22. How do I handle COB claims?**

If after calling (800) 676.BLUE or through other means you discover the member has a COB provision in their benefit plan, and Anthem is the primary payer, submit the claim along with information regarding COB to Anthem, P.O. Box 533, North Haven, CT 06473. If you do not include the COB information with the claim, the member’s BCBS Plan or the insurance carrier will have to investigate the claim. This investigation could delay your payment or result in a post-payment adjustment, which will increase your volume of bookkeeping.

**23. How do I handle Medicare Supplemental (Medigap) claims?**

For Medicare supplemental claims, always file with the Medicare contractor first. Always include the complete Health Insurance Claim Number (HICN); the patient’s complete BCBS Plan identification number, including the three-character alpha prefix; and the BCBS Plan name as it appears on the patient’s ID card, for supplemental insurance. This will ensure cross-over claims are forwarded appropriately.

**Do not file to Anthem and Medicare simultaneously.** Wait until you receive the Explanation of Medical Benefits (EOMB) or payment advice from Medicare. After you receive the Medicare payment advice/EOMB, determine if the claim was automatically crossed over to the supplemental insurer.

**Cross-over Claims:** If the claim was crossed over, the payment advice/EOMB should typically have Remark Code MA 18 printed on it, which states, “The claim information is also being forwarded to the patient’s supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the claim was crossed over, do not file for the Medicare supplemental...
benefits. The Medicare supplemental insurer will automatically pay you if you accepted Medicare assignment. Otherwise, the member will be paid and you will need to bill the member.

**Claim Not Crossed Over:** If the payment advice/EOMB does not indicate the claim was crossed over and you accepted Medicare assignment, file the claim with Anthem. Anthem or the member’s BCBS Plan will pay you the Medicare supplemental benefits. If you did not accept assignment, the member will be paid and you will need to bill the member.

24. **When will I get paid for BlueCard® claims?**

Payment for BlueCard claims is generally made within 5-10 days, and is included in your regular weekly remittance.

25. **Who do I contact for claims questions?**

For claims inquiries, call: (800) 895-9915 (toll free in CT) or (203) 499-6238 (local North Haven)

26. **How do I handle calls from members and others with claims questions?**

If a member contacts you, tell the member to contact their BCBS Plan. Refer them to the front or back of their ID card for a customer service number. The member’s Plan should not be contacting you directly, unless you filed a paper claim directly with that Plan. If the member’s Plan contacts you to send them another copy of the member’s claim, refer them to Anthem.

27. **Where can I find more information about the BlueCard® Program?**

For more information about the BlueCard Program, call the dedicated BlueCard Unit at (800) 895-9915 (toll free in CT) or (203) 499-6238 (local North Haven), or visit the Blue Cross and Blue Shield Association’s Web site at www.bcbs.com.
Glossary of BlueCard® Program Terms

<table>
<thead>
<tr>
<th>Term</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha Prefix</td>
<td>Three characters preceding the subscriber identification number on BCBS Plan ID cards required for routing claims. It identifies the member’s BCBS Plan or national account.</td>
</tr>
<tr>
<td>bcbs.com</td>
<td>Blue Cross and Blue Shield Association’s Web site, which contains useful information for providers.</td>
</tr>
<tr>
<td>BlueCard Access®</td>
<td>A toll-free 800 number, (800) 810-BLUE, for you and members to use to locate health care providers in another BCBS Plan’s area. This number is useful when you need to refer the patient to a physician or health care facility in another location.</td>
</tr>
<tr>
<td>BlueCard Eligibility®</td>
<td>A toll-free 800 number, (800) 810-BLUE, for you to verify membership and coverage information on patients from other BCBS Plans. Calling BlueCard Eligibility will facilitate quicker payments.</td>
</tr>
<tr>
<td>BlueCard® POS</td>
<td>A health benefit program for national companies with employees who are living in your state. The highest level of benefits is received when members obtain services from their primary care provider/group and/or comply with referral and/or authorization requirements for care. Substantial benefits are still provided when members obtain care from any eligible provider without referral or authorization, according to the contract terms.</td>
</tr>
<tr>
<td>BlueCard® PPO</td>
<td>A national program that offers members traveling or living outside of their BCBS Plan’s area the PPO level of benefits when they obtain services from a physician or hospital designated as a BlueCard PPO provider.</td>
</tr>
<tr>
<td>BlueCard® PPO Member</td>
<td>Carries an ID card with this identifier on it. Only members with this identifier can access the benefits of BlueCard PPO.</td>
</tr>
<tr>
<td>BlueCard® Doctor and Hospital Finder Web Site</td>
<td>A web site you can use to locate health care providers in another BCBS Plan’s area—www.bcbs.com. This is useful when you need to refer the patient to a physician or health care facility in another location.</td>
</tr>
<tr>
<td>BlueCard Worldwide®</td>
<td>A program that allows BCBS members traveling or living abroad to receive nearly cashless access to covered inpatient hospital care as well as access to outpatient hospital care and professional services from health care providers worldwide. The program also allows members of foreign BCBS Plans to access domestic (U.S.) BCBS provider networks.</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>A provision that limits the amount of coverage in the benefit plan to a certain percentage, commonly 80 percent. The member pays any additional costs out of pocket.</td>
</tr>
<tr>
<td><strong>Coordination of Benefits (COB)</strong></td>
<td>Ensures that people receive full benefits and prevents double payment for services when a member has coverage from two or more sources. The member’s contract language gives the order for which entity has primary responsibility for payment and which entity has secondary responsibility for payment.</td>
</tr>
<tr>
<td><strong>Copayment</strong></td>
<td>A specified charge that a member must pay out-of-pocket for a specified service at the time the service is rendered.</td>
</tr>
<tr>
<td><strong>Deductible</strong></td>
<td>A flat amount the member must pay before the insurer will make any benefit payments.</td>
</tr>
</tbody>
</table>
| **Direct Care Provider** | An individual or organization that offers care directly to the member. The direct care provider is in the same physical location as the member and offers care to patients from within the local Plan’s service area.  
Examples: 1) a provider who physically examines the patient, 2) a lab that performs the blood draw from a patient, or 3) a technician who fits a prosthetic limb to the patient.  
The direct care provider should file claims to the local BCBS Plan. BlueCard applies if the provider of service is outside the member’s Plan service area and does not contract with the member’s BCBS Plan. |
| **Electronic Claims Routing Process** | A method Anthem uses to electronically forward your claims data to the member’s BCBS Plan for those alpha prefixes or accounts that are exempt from the BlueCard Program. This process will expedite claims resolution and reduce paper. |
| **FEP** | Federal Employee Program |
| **HMO (Health Maintenance Organization)** | A health benefit program that offers benefits to members when they obtain services from the network of physicians and hospitals designated as HMO providers. Generally, HMO members select a primary care provider/group. |
| **Hold Harmless** | An agreement with a health care provider not to bill the member for any difference between billed charges for covered services (excluding coinsurance) and the amount the health care provider has contractually agreed on with a BCBS Plan as full payment for these services. |
| **Home Plan** | When the employer group’s headquarters is located in the service area, this area’s plan has the primary responsibility for selling and servicing the account. |
| **Host Plan** | The area in which a member from a Home Plan account selects a primary care physician is responsible for provider and medical management services for the member. |
| **Indirect Care, Support and Remote Provider (National Provider)** | An individual or organization that offers care to patients from outside Anthem’s service area. Services may be provided from a single site or from multiple locations. The provider of service is the one that files a claim for a service supplied to a member. BlueCard applies if the provider of service is |
outside the member’s BCBS Plan’s service area and does not contract with the member’s Plan. The member’s location at the time of service is irrelevant. Often the patient and the indirect care provider are in different physical locations.

**Medicare Crossover**

The Crossover program was set up to allow Medicare to transfer Medicare Summary Notice (MSN) information directly to a person with Medicare’s supplemental insurance company.

**Medicare Supplemental (Medigap)**

Pays for expenses not covered by Medicare.

**National Account**

Employer group that has offices or branches in more than one location, but offers uniform coverage benefits to all of its employees.

**Network**

The group of physicians, hospitals, and other medical care providers that a specific managed care plan has contracted with to deliver medical services to its members.

**Other Party Liability (OPL)**

A cost containment program that recovers money where primary responsibility does not exist because of another group health plan or contractual exclusions. Includes coordination of benefits, workers’ compensation, subrogation and no-fault auto insurance.

**Plan**

Refers to BCBS Plan.

---

**BlueCard® Program Quick Tips**

The BlueCard Program provides a valuable service that lets you file all claims for members from other Blue Cross Blue Shield Plans to your local Plan.

Here are some key points to remember:

- Make a copy of the front and back of the member’s ID card.
- Look for the three-character alpha prefix that precedes the member’s ID number on the ID card.
- Call BlueCard Eligibility at (800) 676-BLUE to verify the patient’s membership and coverage.

Submit the claim to:

Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473

Always include the patient’s complete identification number, which includes the three-character alpha prefix. The only two exceptions to submitting to Anthem are as follows:

- a member from a BCBS, with which you have a contract, presents an ID card with an alpha prefix
- a member presents you with an ID card without an alpha prefix. This may indicate an account or product (for example, FEP or Medicare+Choice) that may be exempt from the BlueCard Program or the ID card may be outdated.

For claims inquiries, call (800) 895-9915 (toll free in Conn.) or (203) 499-6238 (local North Haven).
11. UTILIZATION MANAGEMENT

Table of Contents

Key Telephone Numbers..................................................................................................................2
Coordination of Care - Nurse Consultants .......................................................................................4
Prior Authorization............................................................................................................................5
  Diagnostic Radiology through National Imaging Associates (NIA)..............................................6
Managed Benefits for Non-HMO Plans............................................................................................6
Maternity...........................................................................................................................................7
  Maternity Admission Notification.................................................................................................7
  Maternity Length-of-Stay Benefits...............................................................................................7
  Home Health Care and Well Baby Visits.....................................................................................7
  Shortened Length of Stay............................................................................................................7
Expedited Review Hotline - Inpatient Care........................................................................................8
Emergency Care ...................................................................................................................................8
  Emergency Admissions Authorization.........................................................................................8
Urgent Care.......................................................................................................................................8
Referrals - Specialty Care ................................................................................................................9
  Authorizations for Out-of-Network Referrals.............................................................................11
Behavioral Health Treatment..........................................................................................................11
Chiropractic, Physical, Occupational, Speech Therapy.................................................................11
Durable Medical Equipment (DME) & Prosthetics.........................................................................11
Concurrent Review..........................................................................................................................12
Community Case Management Programs.....................................................................................12
Proactive Care Management..........................................................................................................13
Clinical Transition Program..........................................................................................................14
Key Telephone Numbers

Utilization Management

Prior Authorization – Inpatient Services
- Urgent/ Emergent Admissions, Transplants (800) 238-2227
- Elective Admissions
- Maternity Notification (high risk) (800) 238-2227 or fax the notification to (203) 985-6460

Prior Authorization - Outpatient Services
- Outpatient Surgery (800) 238-2227
- Diagnostic Radiology Services (NIA) (888) 864-7237
- DME/Prosthetics (call for coverage eligibility) (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven)

Expedited Review Hotline (inpatient care)
(888) 507-8803 or (888) 507-2272

Out-of-Network Referral Authorizations
(800) 238-2227, ext. 5177

Case Management Department
(800) 231-8254 Case Management (203) 239-8649 Clinical Transition

Behavioral Health Treatment
- Anthem Employees (800) 230-3368 (Anthem Behavioral Health)
- BlueCard POS (800) 934-0331 (Anthem Behavioral Health)
- BlueCard PPO and Traditional Call Member’s Home Plan on back of ID Card
- BlueCare Health Plan (800) 934-0331 (Anthem Behavioral Health)
- Century Preferred (888) 604-7533 (Anthem Behavioral Health)
- New England Health Plans (800) 441-6613 (Value Options)
- State of Connecticut (888) 605-0580 (Anthem Behavioral Health)
- Mohegan Sun (ValueOptions) (800) 441-6613
- Taft-Hartley (Teamsters) (800) 287-0032 or check member ID card
- All other plans (800) 253-9875

Utilization Management Overview

Anthem Blue Cross and Blue Shield’s utilization management program is designed as a means for physicians and other health care professionals, hospitals and members to work together with the health plan toward the delivery of appropriate, high-quality and cost-effective member health care.

At Anthem, when it comes to managed care organization excellence, we take our job very seriously. One of the most important services we perform is the utilization management review.

Utilization management review consists of the processes and programs:
- **Prior authorization** Prior approval of the physician’s or health care provider’s treatment plan for coverage, based on medical necessity in advance of treatment or hospital admission.
- **Retrospective review** Cases that are reviewed retrospectively, on an as-needed basis.
Concurrent Review  

**Focused Inpatient Review** A program that targets review of inpatient admissions with a goal of reducing the average length of stay (ALOS) on those diagnoses where the ALOS exceeds national guidelines.

**Admission-based Care Management** A short-term, outpatient case management program that engages patients with specific diagnoses at the time of discharge and up to six weeks following an inpatient stay to reduce readmissions, optimize recovery and reduce long-term complications.

Case management  

A review of a member’s special medical needs and implementation of benefits to match an appropriate treatment plan to help the member reach an optimum level of wellness.

Proactive Care Management  

This program focuses on the early identification and management of individuals with one or a combination of high-risk health factors - before they experience serious medical issues.

Utilization management review procedures are required for members of our HMO and PPO plans with Managed Benefits. Treatment plans are reviewed, and coverage decisions are made by nurses and physicians on our staff. Utilization decisions are based only on appropriateness of care and service.

It is important for you to know that at Anthem the staff reviewing coverage and benefits requests is not specifically rewarded for issuing denials of coverage or services, nor do we provide financial incentives to encourage UM staff to make decisions that result in under-utilization. In considering coverage of the proposed treatment plan, the staff may offer coverage of alternative levels of service or a different approach to treatment that the member’s physician or health care provider may not have considered.

**Utilization Management Review**

Our utilization management review program applies to the following plans and programs:

**HMO Plans:**
- BlueCare and BlueCare Plus
- BlueCare POS (Point-of-Service) and BlueCare Plus POS
- BlueCare Basic and Plus Basic
- BlueCare Direct and Plus Direct
- BlueCare Plus NSB
- BlueCare Plus Premier
- BlueCare Plus Access 10
- HMO Blue New England and Blue Choice New England (New England Health Plans)
- State BlueCare POS, State BlueCare POE and State BlueCare Plus POE

Selected components of our utilization review program apply to members covered under the following programs:

**PPO Plans (For members with Managed Benefits)**
- Century Preferred (including Century Preferred Comp and PCA, Century Preferred Direct, and Century Preferred HSA), State Preferred
- PPO USA (National Accounts)
- Century 90 programs (as required by purchasing group)

*For FEP Standard Option and Basic Option plans, see the FEP chapter of this manual. BlueCare Family Plan is subject to separate policies and procedures.*
Non-standard Coverage - “Carve-outs”
Employer groups covered by any of our products or programs may opt to “carve-out” specific portions of that coverage. Under these circumstances, the following could occur:

- Specific benefit(s) may not be covered that are covered under the standard plan.
- A specific area of coverage (i.e., behavioral health) may be provided by a vendor’s network of providers instead of the standard BlueCare Health Plan or Century Preferred network.
- Information on carve-outs from standard plans may be printed on the member’s ID card. For further information on specific employee group coverage, contact the Provider Call Center.

Coordination of Care - Nurse Consultants

An integral part of Anthem’s health plans is the role of the utilization management nurse in the coordination of services in every aspect of patient care covering a member’s overall experience with the plan. The nurse consultant-member relationship is intended to support our commitment to becoming an involved and supportive partner in assisting members in obtaining quality health care services.

Our nurses work with physicians and other health care providers to help members access care and navigate through the health care system. The nurse’s involvement also is meant to enhance timely data collection needed for the determination of benefits while minimizing the provider’s burden in this process.

Physician/Provider Role and Responsibility
Under traditional programs, many of you as participating providers are accustomed to contacting us on your patient’s behalf when authorization and/or certification are needed for treatment. As the treating physician or other health care provider, you are in the best position to know your patient’s medical condition and health care needs. With this knowledge, you are the key clinical decision-maker and the most appropriate person to provide information by assuming overall responsibility for contacting us when you intend to render certain treatment.

In turn, we will work with you to ensure that our utilization and clinical quality management processes are efficient and user-friendly, and that they minimize your administrative burden while aiding the member in accessing the health care system. Our nurse consultants will help you and the member by collecting and reviewing information, and by researching options.

Utilization Management Departments
Utilization management is comprised of the following departments, staffed by licensed clinical nurses who work cooperatively with our medical management department, physician consultants and other health care professionals:

- Concurrent Review
- Prior Authorization
- Case Management
- Behavioral Health

The inpatient and outpatient services to which these programs apply are:

- Clinical Transition
- DME
- Hospital Admission
- Out of Network Services
- Outpatient Surgery
- Private Duty Nursing
- Behavioral Health Facility Care
- Rehabilitation Care
- Skilled Nursing Facility Care
- Subacute Facility Care
Prior Authorization

In a managed care environment, the prior authorization review process is an important part of the overall Utilization Management program, a part in which a truly cooperative approach is essential. This prior authorization dialogue allows for the exchange of clinical information between the hospital staff, attending and primary care physicians and Anthem’s Utilization Management staff. At the time of this initial contact, criteria and benefit information are shared and reviewed to provide everyone involved with as much information as possible so decisions can be made before care is rendered.

BlueCare Health Plan* and Century Preferred

Inpatient Services
Prior authorizations are required for all inpatient admissions for members of our BlueCare Health Plan and Century Preferred plans and products, (including Century 90 and State of Connecticut plans). This includes, but is not limited to organ transplants, skilled nursing facility care, subacute care and the following specified outpatient surgeries:

Outpatient Services
Prior authorizations are required as follows:

- Diagnostic Radiology Services (888) 864-7237 (National Imaging Associates – see additional information below)
- DME/Prosthetics: (800) 238-2227 (selected services and equipment)
- The following specified outpatient surgeries:
  - Blepharoplasty
  - Breast Surgery (female and male, excluding breast biopsy)
  - Cranial/Facial Surgery
  - Destruction of Cutaneous Vascular Proliferative Lesions
  - Hysterectomy
  - Jaw Surgery
  - Otoplasty
  - Repair of Ptosis
  - Gastric Bypass
  - Rhinoplasty
  - Sclerotherapy
  - Testicular Prosthesis
  - Uvulopalatopharyngoplasty
    (for BlueCare Health Plan only)

Notify Us About Changes to Outpatient Procedures
Once a required prior authorization has been obtained for an outpatient procedure, be sure to let us know if there is any change to the date of service, place of service or physician providing the service. If we are not notified of such changes, and the information on the claim submitted is different from the prior authorization obtained, the claim will be rejected.

* This does not include the BlueCare Family Plan.

Who should call for prior authorization?

BlueCare Health Plan: Under our HMO plans and products:
- It is the participating physician’s or provider’s responsibility to contact our Utilization Management Department at (800) 248-2227 to obtain prior authorizations.
- The request must come from the provider or facility rendering the service, not the referring physician.
- If prior authorization is not obtained, the claim may be denied by the Plan, and the member must be held harmless.

Century Preferred PPO: under our PPO plans and products:
- It is the member’s responsibility to contact our Utilization Management Department to obtain prior authorization.
- However, the physician or hospital may call on the member’s behalf, and is encouraged to do so.
Other Products:

PPO USA, BlueCard PPO, FEP and Taft-Hartley Plans have distinct benefits and prior authorization requirements. Call for information.

- Taft-Hartley: (888) 287-0032
- FEP: (800) 860-2156
- PPO USA (natl. accounts) and BlueCard PPO: Refer to member’s home plan. See back of member ID card.

Diagnostic Radiology through National Imaging Associates (NIA)

- Diagnostic Radiology (NIA) (888) 864-7237

Under the Utilization Management and Quality Management programs, prior authorization or notification is required through NIA for the following non-emergent outpatient diagnostic imaging services for members of most of our commercial plans and products: MRI, MRA, PET, CT, Nuclear Cardiology.

Utilization Management (Prior Authorization requirement): For those plans and programs that require prior authorization for these services, NIA will issue a prior authorization number to the ordering physician/provider to share with the rendering facility/provider.

Quality Management (Notification requirement): Clinical consulting services are provided to physicians/providers ordering MRI, MRA, PET, CT and Nuclear Cardiology diagnostic imaging services for members of specified plans. If services to the member are subject to the Quality Management component, NIA will issue a notification number to the ordering physician/provider to share with the rendering facility/provider.

Important Note: The identified imaging services may be subject to the prior authorization requirement, or the quality management component, or neither, depending on the member’s plan or product. Because of this, the ordering physician/provider should ALWAYS CALL NIA before ordering imaging services for members of any Anthem commercial plan or product. NIA will inform the physician/provider what utilization or quality management requirements may be applicable to imaging services for the particular member.

Managed Benefits for Non-HMO Plans

Managed Benefits is a key feature that requires the member to call Anthem for specific utilization management purposes. It may affect members in all non-HMO Anthem programs, including Century Preferred, Century Preferred Comp, Century Preferred Direct, Century Preferred HSA and PCA, PPO USA, State Preferred and Century 90 programs. To verify if Managed Benefits apply, please check the member’s ID card.

⇒ The physician or hospital may call on the member’s behalf, and is encouraged to do so. Proper compliance with the Managed Benefit requirements will ensure that the provider will receive direct and timely payments for services.

⇒ If the requirements are not followed, the member’s benefits will be reduced in accordance with established non-compliance reductions. Benefits may also be denied for non-medically necessary days and the associated physician services.

Notification Requirements For Members with Managed Benefits

The member or member’s representative must call the Utilization Management Department:

- BEFORE any scheduled inpatient admission, regardless of the reason, no later than one business day before entering the hospital.
- AFTER an inpatient admission for any emergency or urgent treatment. This call must be placed within 48 hours or two business days after being admitted.
All telephone calls required under Managed Benefits should be made during regular business hours from 8 a.m. to 5 p.m., Monday through Friday. If a telephone call cannot be made during regular business hours, the member or their representative may leave their name, telephone number and message. Their call will be returned the next business day.

**Maternity**

**Maternity Admission Notification**

While prior authorization of maternity admissions is not required for any of our commercial plans and programs (this does not include the BlueCare Family Plan), notification of a member’s high-risk pregnancy by their physician is requested. By contacting Anthem on behalf of our members, it will help us to help them maximize the value of their health care benefits. (For maternity benefit information please see the “Maternity” section below, and the member’s specific health plan section.)

*For Maternity Notification (high risk only) call (800) 238-2227 or fax the notification to (203) 985-6460*

**Maternity Length-of-Stay Benefits**

*ALL* Anthem members have the following length of stay time frames, which shall commence at the time of delivery:

- Minimum of 48 hours for an uncomplicated vaginal delivery
- Minimum of 96 hours for an uncomplicated cesarean section delivery

The length of inpatient stay may be shortened to less than the time frames outlined above if this decision is made in consultation with the physician/provider, the mother and the baby’s pediatrician.

**Home Health Care and Well Baby Visits**

**Shortened Length of Stay**

*Home Health Care Visits*

If a decision is made to shorten the length of stay, Anthem benefits include:

- a follow-up Home Health Care visit within 48 hours of discharge by a qualified health care personnel trained in postpartum maternal and newborn pediatric care,
- an additional Home Health Care visit within seven days of discharge.

If our member’s stay is shorter than the coverage provided, Anthem recommends that the member take advantage of these follow-up visits. In order to be eligible for coverage for these home care visits, the member must utilize the services of one of our participating Home Health Care agencies. A nurse skilled in maternal and child health will make two home visits to clinically assess the mother and her baby, and answer any questions.

**Additional Pediatric Visit**

In addition, for Anthem plans with Managed Benefits or BlueCare Health Plan members, if the length of stay is shorter than the coverage provided,

- The member may take her baby for a well-baby visit to her pediatrician or family practitioner within three days of leaving the hospital.
- Benefits for this visit are in addition to the regular schedule of preventive care benefits available under the member’s health plan.
- This visit may be subject to a copay, deductible or coinsurance.

Anthem programs that *do not have Managed Benefits* will not be eligible for the additional pediatric visit, but they are still eligible for the home care visits referenced above. If an Anthem member must
comply with Managed Benefits requirements, his or her identification card will provide the necessary information. (For further information on Managed Benefits, see page 11-6). This benefit is subject to any applicable member cost shares, such as deductibles and coinsurance.

Extended Length of Stay
If, due to complications, a length of stay beyond the above time frames appears to be medically necessary, our concurrent review nurse will coordinate directly with the physician for continued stay requirements.

**Expelled Review Hotline - Inpatient Care**
Participating providers have access to an "expelled review hotline" designed for emergent/life threatening situations. If a member has been admitted to a hospital, and the physician feels that the member's life would be in danger, or illness could occur if the patient is discharged or treatment is delayed, the physician may contact Utilization Management and request an expelled review.

A UM nurse is on call from 8:00 a.m. through 9:00 p.m., seven days a week, to handle these requests. If the physician does not receive a response from Utilization Management within 3 hours from the time the call is made, the admission/extension is considered approved.

For expelled review, call toll free (888) 507-8803, or, if busy, (888) 506-2272.

**Emergency Care**
Members of all of our commercial plans and programs have access to treatment for emergency situations at any participating hospital emergency room 24 hours per day, seven days per week, with no referral necessary from the member's PCP.

**Emergency Admissions Authorization**
Authorization is required within 48 hours or two business days when a member of our HMO plans or PPO programs with Managed Benefits is admitted on an emergent basis. To authorize urgent or emergent admissions, contact the Utilization Management Department at (800) 238-2227 (toll free), or fax the prior authorization to (203) 985-6460. For guidelines, see the “Emergency Admissions Authorization” section under each specific health plan.

A medical emergency is defined by Connecticut state law as “The onset of a serious illness or injury that requires immediate medical treatment, or the onset of symptoms of sufficient severity such that a member reasonably believes that emergency medical treatment is needed.”

With this change, hospitals must code the claims they submit to managed care companies based on presenting symptoms, in addition to final diagnosis. As a result of this definition, managed care companies will consider a member's access to appropriate medical care by recognizing that individuals requiring care are not qualified to self-diagnose emergency medical situations.

**Urgent Care**
*BlueCare Health Plan, State BlueCare, FEP, Century Preferred* (including Century Preferred Comp, Century Preferred Direct, Century Preferred HSA and PCA, PPO USA, State Preferred and BlueCard POS) members have access to a comprehensive, hospital-based urgent care facility network for urgent care 24 hours a day, seven days a week, when the member’s physician may not be available. For an updated listing of urgent care facilities, please see your participating provider directory.
The Urgent Care facilities provide:

- **Triage service** - Medical professionals determine if the patient requires emergency or urgent care. Access to the emergency room is available when medically necessary.
- **Extended hours of service** – available to members at any time.
- **Shorter wait times** - 90% of members must be treated within 60 minutes.
- **Access to hospital facilities** - available hospital equipment, technologies and other on-site ancillary services including x-ray, laboratory and pharmacy.
- **Quality monitoring** via provider audits and satisfaction surveys.

**Urgent Care Criteria:**

1. **No referral is required** for urgent care. However, members are encouraged to contact their PCP in an urgent situation. Members may self-refer to a participating urgent care facility at any time.

2. The urgent care facility must be participating to be eligible for in-network coverage.

3. If the member (not FEP) is admitted to the hospital as a result of a visit to an urgent care facility, the Utilization Management Department must be notified within **48 hours or two business days** of the admission at (800) 238-2227.

   **FEP ONLY**: FEP members must contact FEP within two business days of the admission at (800) 860-2156.

4. Members are responsible for applicable urgent care visit copays. Members are also responsible for a copay for each covered emergency room visit that does not result in an inpatient admission.

5. Services rendered must meet urgent care criteria in order to be eligible for coverage. Urgent care refers to services that can be provided for an injury or illness that is not an emergency, but does require immediate attention. Routine primary care (physical exams), preventive care (routine immunizations), and occupational health care (PT or exams for employment) will be ineligible for coverage as urgent care.

6. Urgent care facilities cannot be used as a "back-up" for the PCP; PCPs who act as care coordinators may not "sign out" to a walk-in center for covering purposes.

---

### Referrals - Specialty Care

**Please Note:** Anthem continues to transition groups out of our **BlueCare Health Plan HMO and POS “Plus” plans**, that require members to obtain referrals for specialty care from their Primary Care Physicians (PCPs) before seeking care from other network providers. Groups will be transitioned to **BlueCare Health Plan HMO and POS plans** that provide the same high level of benefits for covered services, but do not require referrals from PCPs. This transition will continue throughout 2005 for members with group and individual coverage.

Specially care referrals are the process through which patient care is coordinated between physicians, other health care professionals and the health plan. (See below for authorizations for out-of-network referrals.)

- **Referrals are required** for members of **BlueCare Health Plan** programs that use primary care physicians (PCPs) as care coordinators, (i.e. BlueCare Plus, BlueCare Plus POS, BlueCare Plus NSB, BlueCare Plus Premier, State BlueCare Plus POE, BlueCare Plus Basic, BlueCare Plus Direct and BlueCare Plus Access 10).

**Note:** Participating providers must refer members to other participating providers. If this requirement is not followed Anthem may deny payment, and the member will be held harmless.
Referrals are not required for BlueCare Health Plan programs that do not use PCPs as care coordinators (i.e. BlueCare, BlueCare POS), nor for any other Anthem program.

Note: Plans that do not require a referral may, however, include the prior authorization requirements outlined in this chapter.

Certain benefits provided by Anthem (i.e. laboratory, physical therapy) require that a member obtain a prescription from his/her referring physician or health care provider prior to treatment.

Referrals for Covered Specialty Care Must:
- Be for required, medically necessary, specialist treatment.
- Be to a participating provider for the member’s plan, unless out-of-network authorization is received (see “Authorizations for Out-of-Network Referrals” below).
- Be limited to covered benefits.
- Be obtained as required, even in situations that also require prior authorization.

When to Obtain a Referral:
Members require referrals from their PCPs to access medically necessary specialty care not available through the PCP. These include all services not performed by a PCP (except as noted in this section), as well as the following:
- **Chiropractic Services**
- **Physical Medicine Services** (Physical, Occupational and Speech Therapy)
  - In addition to PCPs, the following specialists also may refer for physical medicine services:
    - Orthopedic surgeons
    - Neurosurgeons
    - Physiatrists
    - Rheumatologists
    - Neurologists
    - Plastic Surgeons (after the performance of hand surgery)
- **Audiologic Services**
  - In addition to PCPs, the following specialists may refer for audiologic services:
    - Otolaryngologists
- **Obstetric/Gynecologic Services**
  - Referrals are not required for a member to access OB/GYN services from a participating physician or health care provider, with the exception of infertility treatment. Please refer to specific health plan section for further information on these services.

Other Referral Guidelines
- When a member has been hospitalized under a specialist’s care, and must continue that care in the specialist’s office after discharge, the PCP must issue a subsequent referral, unless a valid referral is still in place.
- **BlueCare Health Plan** referrals have no time limit, unless otherwise noted.
- Specialists who treat BlueCare Health Plan members with plans that require a PCP referral may wish to refer them to other specialists. To do so, the specialist must consult with the PCP who, in turn, may issue the subsequent referral.
- Members may not self-refer if they are enrolled in the BlueCare Health Plan gatekeeper “Plus” products, except for OB/GYN services, as previously noted.
- A properly completed CMS-1500 claim form from the member’s physician or specialist provider must be submitted in order for services to be eligible for coverage. Please see “Completing the CMS-1500 Claim Form” in the Claim Submission chapter of this manual.
- If a member changes his or her PCP while undergoing specialty care, that referral automatically becomes invalid. The member will need a new referral from the new PCP. Services rendered by
the original PCP after the effective date of the PCP change will not be covered. Specialists may call BlueCare Health Plan’s Provider Call Center to verify membership status and PCP information to determine coverage.

- If a new member is undergoing treatment prior to joining BlueCare Health Plan, he or she must get a referral from their PCP upon switching to BlueCare Health Plan, and before continuing treatment, if services are covered by the new program. If the treatment is being rendered by an out-of-plan facility or specialist, the PCP must either refer to a participating provider or request and receive prior authorization from the health plan.

- If a member seeks the services of a physician or health care provider other than his or her PCP, and does not have a referral, the provider should call the PCP directly to obtain one.

**Authorizations for Out-of-Network Referrals**

In the event that you must refer a patient to a non-participating physician or health care provider because the specialty services are out of the ordinary and can’t be provided by a participating physician or health care provider, you must contact the Utilization Management Department at (800) 238-2227, ext. 5177.

**Behavioral Health Treatment**

Telephone numbers for behavioral health services are included in the “Key Telephone Numbers” section of this chapter. Utilization management guidelines for behavioral health services vary according to health plan. For further information, please refer to the “Behavioral Health” section in the chapter that covers the member’s specific health plan.

**Chiropractic, Physical, Occupational, Speech Therapy**

To make sure the member has coverage for Chiropractic, PT,OT or ST visits, it is important to always take the following steps:

1. **Ask the member if they have had other Chiropractic, PT,OT or ST visits during the calendar year.** These visits will count toward the member’s benefit limit.

2. **Always call for member eligibility and benefits.** This will allow you to check on the amount of coverage still available under the member’s plan.

While prior authorization is not required for Physical Therapy, Occupational Therapy, Speech Therapy and Chiropractic services for members of our commercial plans and programs (not including the BlueCare Family Plan.), we are still charged with the important task of monitoring appropriateness of utilization. To this end, we will continue to oversee the utilization of these services in order to identify variances from the norm, which will be handled on an individual basis.

**Durable Medical Equipment (DME) & Prosthetics**

Coverage and utilization management requirements for DME/prosthetics vary depending upon the member’s health plan. Please reference the specific health plan section for basic coverage, or call (800) 922-3242 (toll free in Conn.) or (203) 239-3884 (local North Haven) for more information.
Concurrent Review

The process through which patients' ongoing care is evaluated as the care is being given. This is achieved by working with the hospital Utilization Management Department, the physician, the member and the consulting physician reviewers. The focus of concurrent review is to better manage the continuity of the member's care from the acute care setting to the subacute level of care, or at home with skilled nursing services.

Concurrent Review includes our Focused Inpatient Review and Admission-based Care Management programs.

The **Focused Inpatient Review** program targets review of inpatient admissions with a goal of reducing the average length of stay (ALOS) on those diagnoses where the ALOS unjustifiably exceeds national guidelines.

**Admission Based Care Management** serves to proactively identify those hospitalized members who would benefit from outreach services, care coordination, education and follow-up to improve their health and optimize the cost of quality care. The targeted diagnoses for the program are: cardiovascular disease and diabetes mellitus.

The Admission Based Care Manager will perform case management activities in order to decrease hospital re-admissions and avoidable services, improve long-term outcomes by ensuring appropriate follow-up, support adherence to the prescribed medical regimen and encourage the appropriate lifestyle changes.

This is designed as short-term case management and will incorporate educational materials and tools as developed by Anthem’s Population Health Management Program and will coordinate with the Proactive Care Management Department for longer term case management as deemed necessary.

Community Case Management Programs

**Available for Members of all of our commercial plans and programs**

**Anthem Blue Cross and Blue Shield Responsibilities:**

- Accept referrals and engage in case finding to identify members with targeted diagnoses.
- Coordinate care needs with the PCP, specialty providers, member and family, and authorize services from the benefit plan.
- Perform face to face assessments, if necessary, of identified members and maintain ongoing communication with members, families and providers.
- Research and refer to community resources that augment the member's benefit package.
- Identify and maximize opportunities where quality impacts and cost savings overlap.
- Evaluate programs and seek improvements.

**Physician/Provider Role:**

- Identify and refer members appropriate for case management as early as possible.
- Work collaboratively with Anthem case managers and other health care team members.
- Provide ongoing feedback about our current case management programs and how we can better work together to meet the needs of our members.

**Case Management Programs:**

**Medical/Surgical**

- Asthma
- Brain Injury
- Cancer
- Cardiac Disease
- HIV
- Neuromuscular Disease
- Pediatric
- Premature Newborns
Referral Criteria for Case Management

When you or Anthem identifies the following criteria for one of our members, they may be referred to the Case Management program.

<table>
<thead>
<tr>
<th>Potential Health Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chronic Pulmonary Disease</td>
</tr>
<tr>
<td>High Risk OB</td>
</tr>
<tr>
<td>Spinal Cord Injury</td>
</tr>
<tr>
<td>Trauma</td>
</tr>
<tr>
<td>Transplants</td>
</tr>
<tr>
<td>Solid Organ</td>
</tr>
<tr>
<td>Bone Marrow</td>
</tr>
<tr>
<td>Behavioral Health</td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Dually Diagnosed Patients</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychological Disorders</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
<tr>
<td>Solid Organ</td>
</tr>
<tr>
<td>Schizophrenia</td>
</tr>
<tr>
<td>Bone Marrow</td>
</tr>
<tr>
<td>Dually Diagnosed Patients</td>
</tr>
<tr>
<td>Child &amp; Adolescent Psychological Disorders</td>
</tr>
<tr>
<td>Eating Disorders</td>
</tr>
</tbody>
</table>

For further information contact the Case Management Department at (800) 231-8254.

Proactive Care Management

Our Proactive Care Management Program (PCM) focuses on the early identification of individuals with high-risk health factors - before they experience serious medical issues.

A sophisticated predictive modeling tool is used to prospectively identify our most chronically ill members who are likely to be admitted to the hospital within a year, and who have the most opportunity for improved health outcomes. This tool has helped us identify members regardless of the type of chronic diseases and/or illnesses they may have, rather than just focusing on a single disease type.

Under PCM, we also accept catastrophic care management referrals for members who have experienced sudden unforeseen illnesses or injuries that meet our program's criteria. These referrals may also come from the hospital care managers, the referral management nurse and/or the nurses who review for prior-authorization of services. Referrals may come from physicians, facilities, members/families, group accounts, and customer service. Members may access these services by calling our toll free number or through our Web site. Obstetrical providers may also complete a maternity notification form that can be faxed or completed on our Web site to help us identify high-risk maternity members for participation in the maternal/child care management program.

Once a member agrees to participate in our voluntary program, our care managers contact the member as frequently as necessary to help members with their health and wellness issues and concerns; to increase their knowledge about their health, to assist with accessing and navigating covered insurance benefits and community/governmental supports. Motivational counseling and support is also provided to help members overcome the obstacles that prevent them from leading a healthier lifestyle and achieving their health objectives. These techniques empower members to become more confident and informed in their health care decisions both from a wellness and disease perspective.
Our proactive care management program is based on the premise that all key players—the member, their family, physicians, hospitals and home-health services—are engaged and communicating with one another. This collaboration and coordination leads to a more significant and positive impact in improving health outcomes.

Proactive Care Management may include the following specialties:
- High Risk Maternity
- Transplant
- Oncology/Hospice
- CVD/Diabetes
- Respiratory (Asthma, COPD, etc.)
- Neuro/Rehabilitation (Trauma, ALS, etc.)
- Pediatrics
- Medical

Clinical Transition Program

This program is designed to aid the member who is transitioning into an Anthem health plan from another health plan by providing cost-effective, personalized care. A nurse consultant will facilitate ongoing, covered medical and behavioral health care, and transition the care into the member’s new provider network and benefit design.

The new member will be assisted with the appropriate components of the utilization management program, including prior authorization, certification of emergency or urgent care, concurrent review, case management, treatment planning, specialty referrals and behavioral health management (mental health/substance abuse).

The Goals of Clinical Transition are:
- To facilitate a smooth transition for the member into his or her new Anthem health plan.
- Identify complex health care problems.
- Assist our members and their new physicians in maintaining well-coordinated, quality health care and benefit options.
- Minimize lapses in our members’ health care.

The Clinical Transition Program is available to:
- Members whose physicians are not currently participating in the network servicing the member’s new Anthem health plan.
- Members who are currently receiving covered medical and/or behavioral health services.
- Members who have scheduled inpatient or outpatient surgery and/or inpatient behavioral health services that will occur within 30 days from the start of their new health benefit plan.
- Members who are in their third trimester of pregnancy.

NOTE: Members transitioning into a BlueCare Health Plan program from another health insurance carrier will have the standard 30-day transition period (unless otherwise arranged) during which they must identify physicians or health care professionals who participate in their new Anthem health plan.

Physician Responsibility:
The member’s physician must contact the Utilization Management Department on their patient’s behalf if the services they are undergoing or have scheduled require prior authorization, regardless of whether or not they were required to obtain prior authorization from their previous health plan.

Services Eligible for Clinical Transition:
- Specialty care services
- Pregnancy-related services; members in their third trimester of pregnancy
- Scheduled inpatient or outpatient surgeries
Case management of chronic or terminal illness
Transplant services
Physical, occupational, speech, cardiac or allergy therapy
Chiropractic services
Home care services
Intravenous therapy
DME/prosthetics
Infertility services
Behavioral health services

Services that do not require Clinical Transition:

- Medically necessary services which are eligible for coverage and are being performed by a physician or health care professional who participates in the network serving the member’s new Anthem benefit plan do not require clinical transition processing.

Who to Call: For further information on Clinical Transition call the Provider Call Center at (800) 922-3242 (in Connecticut) or (203) 239-3884 (local North Haven).
12. QUALITY MANAGEMENT

Table of Contents

Key Telephone Numbers.................................................................2
Quality Management Overview ..................................................2
Population Health Management ..................................................2
  Clinical and Wellness Programs and Services ..........................3
  Health Education Programs ....................................................4
  Preventive Programs ...............................................................4
SpecialOffers@Anthem Program ..................................................5
Medical Policy ...........................................................................8
  Medical Policy Research, Development and Implementation .....8
Provider Performance Measurement ..........................................8
Accreditation and Oversight ......................................................9
  Clinical Medical Record Review ..............................................9
Practice Guidelines .................................................................12
Provider Advisory Panels ..........................................................12
Key Telephone Numbers

Health Education Programs

<table>
<thead>
<tr>
<th>Program</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes Education Program</td>
<td>(800) 922-1742 ext. 7086 (toll free) or (203) 985-7086 (local North Haven)</td>
</tr>
<tr>
<td>Asthma Education Program</td>
<td>(800) 922-1742 ext. 5823 (toll free) or (203) 239-5823 (local North Haven)</td>
</tr>
<tr>
<td>Cardiovascular Program</td>
<td>(800) 922-1742 ext. 6171 or (203) 985-6171 (local North Haven)</td>
</tr>
<tr>
<td>Depression Education</td>
<td>(800) 922-1742 ext 7086 or (203) 985-7086 (local North Haven)</td>
</tr>
</tbody>
</table>

Quality Management Overview

Anthem Blue Cross and Blue Shield’s commitment to Quality Management supports our vision of being the leading managed care company in the state. Quality Management programs support the concept of continuous quality improvement in an effort to promote:

♦ Improved Health Status for Members
♦ Continuous Improvement in Quality Care and Service
♦ Customer Satisfaction

The Quality Management staff works with physicians and other health care professionals in a collaborative effort to attain the highest level of quality of care and service for our members. Data analysis of clinical indicators and benchmarks against national and local standards are the basis for the Quality programs. The ultimate goal of these programs is to improve the health outcomes of our members.

The Health Care Management Division at Anthem has several areas dedicated to improving the health of the people we serve and supporting quality of care, including:

- **Accreditation and Oversight** – NCQA, HEDIS, Medical Record Review and Clinical Quality Complaints and Sentinel Events
- **Population Health Management** – Disease Management Programs, Practice Guidelines and Prevention
- **SpecialOffers@Anthem** – value-added program
- **Provider Performance Measurement** – Clinical Quality Program, Quality Improvement Initiatives
- **Medical Policy** - responsible for the research and development of medical policy

Population Health Management

At Anthem, we are committed to providing preventive materials and health education programs to assist members in living a healthy lifestyle. As part of these efforts, our Population Health Management staff works in collaboration with participating physicians to design programs that help our members -- your patients -- attain the highest level of good health.

Based on the differing needs of our membership, specific preventive, educational and value added programs are offered to members of our commercial plans and programs.
**Prevention Programs**
You know that preventive care is the first line of defense against illness. Our prevention programs help members stay well. As part of our programs, members are sent educational materials and friendly reminders to schedule periodic preventive screenings and well care visits to detect problems before they become more serious.

**Health Education Programs**
The plan also provides health education programs to help members with chronic conditions effectively manage their disease. We encourage your assistance in referring members to these educational programs. They are designed to help members acquire self-care skills that can help improve their quality of life. As an important component of the programs, health outcomes are measured to assess the effectiveness of our educational programs.

**SpecialOffers@Anthem Value Added Program**
In addition to the clinical quality and education programs for our members, Anthem also provides value-added programs and services to bring further value to our members. These include a wide range of discounted health-related products and services. Examples are savings on fitness club memberships, vision wear, wellness books, and other health-related items.
* Please refer to the description on page 12-5.

**You Can Help!**
Our health education and preventive programs are offered at no extra charge to members. As a participating provider, you can help by encouraging members to take advantage of the programs available to them.

**Clinical and Wellness Programs and Services**

**Health Education Programs**
- Asthma Education Program
- Cardiovascular Program
- Depression Education
- Diabetes Education Program

**Preventive Programs**
- Breast and Cervical Cancer Screening
- Childhood and Adolescent Immunization Program
- Colorectal Cancer Screening
- Influenza Prevention Program
- Obesity
- Preventive Health Guidelines
- Patient Safety Programs

**Health Information Services**
*MyHealth@Anthem® located on the anthem.com Web site*
Health Education Programs

Asthma Education

The Asthma Education Program furnishes members with up-to-date information on the causes, triggers, symptoms and treatment of asthma. The program targets members at various severity levels and ages who have been referred through their physician, recent inpatient or emergency visits or other internal departments. Members participate through comprehensive home educational mailings and disease-specific newsletters. In addition, there is also valuable information in the asthma and allergies self-care center on the MyHealth@Anthem® section of our Web site, anthem.com.

Contact: (800) 922-1742 ext. 5823 or (203) 239-5823 (local North Haven).

Cardiovascular Program:

Educational materials are available for in-home study through the mail that promote awareness about cholesterol management, controlling blood pressure and the importance of semi-annual office visits. In addition, there is also valuable information in the heart disease and high blood pressure self-care centers on the MyHealth@Anthem® section of our Web site, anthem.com.

Contact: (800) 922-1742, ext. 6171 or (203) 985-6171 (local North Haven).

Depression Education:

Depression screening tools, practice guidelines and patient education materials are available to assist providers with diagnosing and treating depression. In addition, there is also valuable information in the depression self-care center on the MyHealth@Anthem® section of our Web site, anthem.com.

Contact: (800) 922-1742, ext. 7086 or (203) 985-7086 (local North Haven).

Diabetes Education:

The goal of the diabetes education program is to help our members with diabetes acquire the important self-care skills that will enable them to manage their disease effectively. Features include conveniently scheduled classes with participating certified diabetes educators and nutritionist consultations, a biannual newsletter and helpful educational materials that provide information on how to manage diabetes, develop necessary lifestyle modification skills, recognize and treat emergency situations, and avoid complications. In addition, there is also valuable information in the diabetes self-care center on the MyHealth@Anthem® section of our Web site, anthem.com.

Contact: (800) 922-1742, ext. 7086 or (203) 985-7086 (local North Haven).

Preventive Programs

Effectiveness of Breast Cancer and Cervical Screening Programs

Cancer is most treatable in its earliest stages. Regular mammograms, along with a clinical breast exam by a trained practitioner and early treatment, can reduce mortality associated with breast cancer. One of the most important things women can do to reduce their risk of cervical cancer is to receive regular screenings with a Pap Test. Recognizing the value of screening and early detection, interventions involving breast health, cervical cancer, and colorectal cancer information and education are directed towards members and providers in order to increase the screening rate. The program is dedicated to reminding women to participate in health care decision-making with their physicians, and to provide information to promote optimal health and disease prevention.

Colorectal Cancer Screening Program

Colorectal cancer is highly preventable, treatable and often curable. Regular screening tests may detect pre-cancerous polyps. Removing these can prevent cancer from developing. Screening tests can also help detect colorectal cancer in its earliest, most curable stages. Recognizing the value of screening and
early detection, member and provider interventions involve colorectal health information and education in order to increase the screening rate. The program is dedicated to reminding men and women to participate in health care decision-making with their physicians and to provide information that promotes optimal health and disease prevention.

**Childhood and Adolescent Immunizations**

Vaccines prevent disease in the people who receive them and protect those who come into contact with unvaccinated individuals. Vaccine-preventable diseases have a costly impact, resulting in doctor’s visits, hospitalizations, and premature deaths. Sick children can also cause parents to miss time from work. Recognizing the value of immunizations, our goal is to educate and remind parents about the importance of obtaining recommended vaccinations for children and adolescents. Both members and providers receive information about the preventive health guidelines and recommended immunization schedule.

**Obesity Program**

Anthem implemented an obesity program with the following goals: reduce the Plan's rate of overweight and obese members and increase the exercise level in members to four or more days per week. To achieve these goals, the Plan will distribute weight management tools to providers, provide worksite pedometer programs to key accounts, provide education on weight management to chronic disease populations, increase online resources for weight management, investigate appropriate benefit design and provide incentives to members to increase physical activity and promote other healthy behaviors.

**Influenza Prevention Program**

Our flu prevention program is designed to assist members in understanding what influenza is, how to avoid it, and the importance of getting an annual flu shot. Members with chronic conditions that place them at risk for complications from the flu are mailed a reminder to get a flu shot.

**Preventive Health Guidelines**

Building a healthy lifestyle includes proper nutrition, exercise, receiving the appropriate vaccinations, and understanding risky behaviors. Our Preventive Health Guidelines are available to members upon request, and include important preventive guidelines in age-specific categories, as well as information for pregnant women. These guidelines are available also on our Internet site.

**SpecialOffers@Anthem Program**

The following value-added offerings are available to members of the BlueCare Health Plan and Century Preferred programs.

*(The following are not covered benefits. No referral is necessary. Members are obligated to pay the vendors in accordance with the vendors’ payment terms, less any applicable discount.)*

**Fitness and Weight Loss**

**Appalachian Mountain Club (AMC)**

New and renewing members can receive a 20 percent discount on the Individual or Family membership rate. AMC membership includes discounts at AMC huts and lodges, books and workshops and includes a subscription to the AMC Outdoors magazine.

**Fat Loss Coach Customized Fat Loss System**

Receive a 15 percent discount on customized weight loss programs.

**Fitness Club Memberships**

We've arranged for our members to receive the lowest rate for the type of membership selected at an International Fitness Club Network (IFCN) facility.

**Jenny Craig**

Receive discounts on Jenny Craig weight loss programs and the Jenny Direct at home program.
Martial Arts
Members can receive a 15 percent discount on published prices on their first year's tuition for any of the Tang Soo Do Mi Guk Kwan programs.

Performance Health Monitors
Members can receive 10 percent off already discounted prices on pedometers, heart rate monitors and blood pressure monitors through www.powergadget.com.

Rob Nevins' Personalized Weight Control Program
Members are eligible for a free consultation and a 15 percent discount on the program. A 15% discount is also available for online programs.

Vitamins, Supplements and Health-Related Products
Receive up to a 40 percent discount and free standard shipping on thousands of dietary supplements and other wellness products from Healthyroads, Inc.

Weight Watchers® Meetings
At any time, members can enjoy free registration to join traditional Weight Watchers meetings.

Weight Watchers® At Home Kit
Members can receive a $10 discount on the convenient at home kit, making the cost $89.95 (plus shipping and handling fees).

Weight Watchers® Online
Members are eligible for $10 off a three-month subscription to Weight Watchers Online, making the total cost per member $55.00.
*Note: Members who already attend Weight Watchers meetings can sign up for Weight Watchers eTools - online weight loss tools designed to complement the weekly meetings.*

Wellness and Safety

Acupuncture
Members can receive a 15 percent discount on services provided by our contracted acupuncturists.

Allergy and Asthma Relief Products
Members are eligible to receive a 15 percent discount off National Allergy Supply's already discounted prices for environmental control products such as pillow and mattress encasings, air filtration products, compressors/nebulizers and personal care products.

babystyle®
Members can receive a 15 percent discount at babystyle, a source for baby, maternity, and health and safety items. babystyle’s high-quality assortment includes car seats, baby health and safety supplies, and breast feeding items.

Bicycle and Inline Skating Helmets
*Troxel Cycling and Fitness* safety helmets are available to members at discounted prices. These helmets are approved by the American Society for Testing and Materials (ASTM) and Consumer Product Safety Commission (CPSC). Available in a variety of sizes and models.

Eldercare Services
Members receive a 20 percent discount on Eldercare and Assessment Services designed to help elderly individuals live safely and independently. Also receive free service for the first 90 days of the HelpLink Medical Alert System. Discounts available for members and their aging parents.
Health and Beauty Items
Receive a 5 percent discount and free shipping on orders of $49 or more on over-the-counter drugs, fitness equipment, and health and beauty items from Drugstore.com.

Hearing Aids, Evaluations, and Accessories
Savings of at least 20 percent on conventional hearing aids, and 10 percent on programmable and digital hearing aids available through HearUSA®.

Massage Therapy
Members can receive a 15 percent discount on services through our contracted massage therapists.

Medical ID Bracelets and Pill Boxes
Receive a 10 percent discount and free standard shipping on medical ID bracelets, pill box timers, and medication reminders. Lauren's Hope offers a wide variety of stylish, custom made medical ID bracelets that can be engraved and are available for any medical condition or allergy.

Nutritional Counseling Services
Members can receive a 15 percent discount on services provided by our contracted registered dieticians. Note: BlueCare Health Plan members are eligible for this value-added program once they've exhausted their medical plan benefits which provide three nutritional counseling visits per year.

Safety Products and Baby Care Accessories
Members are eligible for a 20 percent discount on products from Safe Beginnings®, which offers a large selection of child and home safety products, including safety gates, latches, outlet covers, fire escape ladders and carbon monoxide detectors.

Wellness Books
Members can receive an additional 5 percent savings off the everyday low prices of featured wellness titles at Barnes & Noble.com. Free standard shipping is available on all orders over $25.

Vision and Dental

Cosmetic Dentistry Services
Members can receive a 15 percent discount off cosmetic dentistry services, which include veneers and tooth bleaching, as well as fabricated athletic guards, through our contracted dentists.

Vision Discounts through TruVision™: Contact Lenses and Laser Eye Surgery Discounts
TruVision, one of the largest administrators of vision services in the country, offers members significant discounts on the following services:
- Discount Contact Lenses
  Working with all the major contact lens manufacturers makes it possible for TruVision to offer contact lenses to members at significant savings and mail them to their home.
- Laser Vision Correction
  TruVision has contracted with Connecticut-based surgeons who are credentialed in refractive surgery and use FDA approved equipment to perform laser vision correction. Members can take advantage of the latest advances in laser correction at a member cost of only $895 per eye.

Vision Wear Discounts
Members can purchase brand-name vision wear at discounted prices from contracted vendors. Members can receive the following discounts:
- 25 percent discount on regular retail frames and lenses
- 20 percent discount on contact lenses
- 10 percent discount on eye accessories
Note: Discounts can not be applied to exams, disposable contact lenses, professional fees or fittings.

All of these offerings are continually evaluated and expanded so the offerings may change. Any additions or changes will be communicated on our Web site, anthem.com. These arrangements have been made to add value to our members. Value-added services and products are not covered by the health benefit plan. Available discount
percentages may change from time to time without notice. Discount is applicable to the items referenced. Anthem cannot assume any responsibility for the failure of vendors referenced to make available discounts negotiated with Anthem; however, any such failure to receive discounts should be reported to the member services department at the toll-free number shown on member ID cards.

Medical Policy

The office of Medical Policy and Technology Assessment (Office of MPTA) is responsible for the research and development of medical policy. This office regularly reviews and evaluates the eligibility for coverage of both new and emerging medical technologies, and new applications of established technologies, including medical procedures, devices and selected drugs, to ensure that Anthem has timely and important information about new technologies for purposes of determining coverage. Existing policies are reviewed periodically and may be revised to reflect advances in medical technology.

Medical Policy Research, Development and Implementation

Research for development of Medical Policy involves a thorough search and review of specialty society and governmental agencies’ positions and consensus reports; peer reviewed scientific literature; Food and Drug Administration (FDA) approval status; and purchased research from technology assessment services (e.g. Blue Cross and Blue Shield Association Technology Assessments, and HAYES Medical Technology Directory® reports). Anthem also asks external physicians from academic medical centers and community practice to review and comment on medical policies, and this input is considered carefully in establishing coverage positions along with input from local multidisciplinary work teams at each Anthem site. These teams identify legislative mandates and member certificate language that may influence if a medical policy is applied locally.

Anthem conducts periodic reviews of medical policies to help accomplish the following:

- The continuous improvement of tools that help educate providers about benefit plan coverages and current medical developments.
- A means for increasing member satisfaction and improving health outcomes for our members.
- Means to measure performance to established guidelines.
- A uniform basis for decision determination during the appeal and complaint process.

The Medical Policy and Technology Assessment Committee, comprised of medical directors and external practicing physicians from each region in which Anthem offers health plans, authorizes medical policy. Anthem fully discloses all medical policy and announcements are published in conjunction with the Connecticut bimonthly Network Update for Physicians and Professional Health Care Providers. All policies may be viewed in their entirety in the Connecticut Physicians and Providers section of the anthem.com Web site.

Provider Performance Measurement

The Anthem Quality Insights Programs

Anthem evaluates and financially rewards health care institutions and providers for achieving measures related to preventive care, quality of care, clinical outcomes, patient safety and patient satisfaction.

The 2005 Quality Incentive Programs

The Primary Care Quality Incentive Program represents an exciting initiative with our participating primary care providers throughout Anthem’s Northeast region (Connecticut, Maine and New Hampshire). The goal of the program is to reward performance for primary care services based on industry standard measures of quality, including clinical outcomes, patient safety and administrative processes that enhance patient care.

The Anthem Quality Insights Hospital Incentive Program (Q-HIP™) is offered to participating hospitals in the Northeast region (Connecticut, Maine and New Hampshire). The goal of the program is to align
financial incentives to improve patient safety, patient health outcomes, and patient satisfaction. The actual performance objectives are based on safety and care processes as promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Leapfrog Group and other respected authorities.

The programs are just two components of *Anthem Quality Insights*, a suite of innovative quality recognition and health improvement programs that are designed to help address the most pervasive and costly health concerns in our region. *Anthem Quality Insights* redefines the relationship that health care providers traditionally have had with insurers by creating a mutually beneficial, patient-focused collaboration that is right for today’s environment.

### Accreditation and Oversight

#### Clinical Medical Record Review

**Overview**

The Clinical Medical Record Review verifies that the physician’s office medical records meet Anthem Blue Cross and Blue Shield and NCQA standards, which focus on continuity and process of care, in order to promote the delivery of quality care and service to our members.

The Medical Record Review Program consists of a medical chart review for physicians serving members in our *BlueCare Health Plan* and *BlueCare Family Plan* programs. The review is performed by Anthem registered nurses. This information is then utilized in ongoing physician practice monitoring and the recredentialing process.

The Clinical Medical Record Review enables Anthem to measure individual performance against established standards, to reinforce good performance, and to identify physicians whose performance varies significantly from their peers.

The Clinical Medical Record Review is based on national criteria from the Blue Cross & Blue Shield Association Quality of Care Program, JCAHO standards for ambulatory care, AMA recommendations for medical records, NCQA standards for medical record review, and, as a requirement by the State of Connecticut for Medicaid providers, EPSDT (Early Periodic Screening Diagnosis and Treatment) compliance standards. (For a complete list of EPSDT standards, see the *BlueCare Family Plan* provider manual.)

The medical record provides documentation of pertinent facts and observations about an individual's health history including present illnesses, tests, treatments, and outcomes in a chronological manner irrespective of diagnosis. The medical record enables the physician and other health care professionals to plan and evaluate the patient's treatment and promote continuity of care among physicians and other health care professionals involved with the patient's care.

**Review Procedure**

**Provider Selection:**

* Annually; a sample of PCPs with members who have had an inpatient admission, same day surgery, or home health services.
* Providers must be participating in our plans.
* The types of physicians to be reviewed include Family Practitioners, General Practitioners, Internists, Pediatricians, OB/GYNs and Doctors of Osteopathy.
* For the *BlueCare Family Plan* (Medicaid), Physician Assistants and Nurse Practitioners are reviewed.
Review Process:
∗ The provider has the option to have an onsite review by an Anthem RN or to mail records in to Anthem.
∗ If the review of a member’s medical charts takes place at the provider’s primary office location, it will occur during regular business hours, when the office is least busy, by RNs from the Anthem staff.
∗ The review routinely takes one to two hours for five to ten records.
∗ An initial contact letter, random sample patient list, and a copy of standards for the review are sent to the provider prior to the review.
∗ The office is contacted by phone to answer any questions, set up an appointment or explain the process for sending records in.
∗ The M.D. does not have to be present at the review unless he/she chooses to be.
∗ An RN reviewer performs the review independently, but may have some questions for the office staff during the review process. Following the review the provider receives a report of the findings.
∗ What’s needed: Space to accommodate our laptop computer, the nurse reviewer and the records.

Review Results:
∗ Following the review, the provider will receive a detailed report of the reviewer’s findings for each of the standards reviewed.
∗ Providers are expected to meet the first eight standards with a score of 90 percent or greater.
∗ Providers who meet the standards will be reviewed again in two years.
∗ Providers who do not meet the standards with a score of 90 percent or greater will be reviewed by the medical director and may be requested to submit a corrective action plan for approval.
∗ Corrective Action Plans will be monitored and the physician will be re-reviewed within six months to one year, depending on the review findings.

Anthem East Medical Record Standards
Medical record standards are established to help facilitate communication, coordination and continuity of care, and to help promote good professional medical practice and appropriate health care management.

Goal: To help ensure that medical records are maintained in a manner which is current, detailed, and organized for all Anthem members who are treated by a health care practitioner. To help ensure these medical records permit effective communication between providers, efficient treatment, confidential patient care, and quality review.

Performance Goals
Each reviewed physician/practitioner or practice site must achieve an overall score of 90 percent or greater on the Medical Record Review.

Access and Availability
Physician/Practitioner or practice sites shall maintain patient records in such a manner that permits timely and easy access to patient information for each patient/provider encounter or, upon request by other legitimate users.

Confidentiality
Patient care offices or sites shall meet or exceed state and federal confidentiality requirements, including HIPAA, and are expected to have implemented mechanisms that guard against unauthorized or inadvertent disclosure of confidential information.

Medical Records should be kept in a secure environment, away from public access.

Patient care offices or sites should be able to provide Anthem, upon request, a written Policy and Procedure for the Release of Patient Information that demonstrates confidentiality of all patient information in accordance with applicable state and federal laws.
# Documentation Standards

## Patient Identification

Every medical record shall contain the following documentation and evidence:

- Patient name or ID number (identification number) is on all pages.
- Personal/biographical information is available (date of birth, patient address, employer, home/ work telephone number(s)).

## Overall Quality of Medical Records

All medical record entries are:

- Signed or co-signed
- Dated
- Legible

## Problem List

Problem list contains the following documentation:

- History of current medical conditions are noted and dated.
- Past medical history noted, easily identifiable, and includes serious accidents, operations, and illnesses for members having at least three (3) visits.
- Health maintenance is noted.
- Problem list is updated as necessary.

## Allergies/ Adverse Reactions

Medication allergies and adverse reactions are prominently noted and dated in the record. If no known allergies, this must be noted.

## Tobacco, Alcohol or Substance Use

Should be a documented part of all routine preventive care.

## Continuity and Coordination of Care

There should be evidence that:

- **Labs/tests:**
  - Results of all diagnostic tests or studies are reviewed by the primary care practitioner (PCP). This may be shown by initialing the results or documented in comments.
  - There are explicit follow-up plans for all abnormal labs or test results.
  - Indication that the patient has been notified of abnormal test or lab results.

- **Consults**
  - Consultant's report or documentation of discussion with consulting physician should be in the medical record.
  - The consultant's report and/or specialty care providers summary has been reviewed by the provider. This may be shown by initialing the results or documented in comments Follow-up Plans.
  - Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls, or visits. The specific time of return is noted in weeks, months, or PRN.
  - There will be notation of any instructions given to patient regarding follow-up visits, care, treatment, or medication schedules.

## Immunization Record

Childhood, adolescent and adult immunizations per Anthem Preventive Guidelines should be documented.

## Preventive Services

For Primary Care Physicians, there is evidence that preventive screening and services have been offered or performed in conformance with generally accepted preventive care practice guidelines. Refer to the Anthem Preventive Health Guidelines for more information.

- Childhood, adolescent and adult immunizations are up to date.
- Cholesterol screening for men over 35 and women over 45.
- Pap Test for women over age twenty-one (or earlier if sexually active) and at least every three years thereafter.
- Clinical breast exam for women based on developmental appropriateness as part of routine preventive care.
- Prostate exam for men annually beginning at age 50 and discussion of risks and benefits of Prostate Specific Antigen (PSA).
- Fecal occult blood testing annually, sigmoidoscopy every five years, double contrast barium enema every five years or colonoscopy every ten years after age fifty.
- Lead screening at age one and two based on community or individual risk.
- Age appropriate counseling or anticipatory guidance.
- Advising pre-adolescent, adolescent, and adult patients against the use of tobacco, alcohol and substances.
- Screening for depression based on patients presenting symptoms/complaints.

**Review Results**

Written results of the medical record review will be provided the day of the audit for on-site reviews. A written summary will be sent to the provider within fifteen business days of completion of the review for records mailed to the Plan.

**Medical Record Improvement Plan**

Practice sites that fall below the medical record threshold of 90 percent will be required to submit a medical record quality improvement plan. Anthem can make available medical record tools and counseling on medical record standards or prevention monitoring as appropriate.

**Follow-up to Medical Record Improvement Plan**

Those practice sites that fall below the medical record threshold of 90% will be reviewed again within six to twelve months.

Those who continue to fall below the threshold at the second review will be referred to the Plan Medical Director.

**Practice Guidelines**

Practice guidelines are generally accepted clinical principles or standards of care that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. Practice guidelines are for the typical patient in the typical situation, and are developed by a formal process that incorporates the best scientific evidence of effectiveness. Practice guidelines standardize care for acute, chronic and preventive conditions in an attempt to determine the most cost-effective and clinically effective treatments. Provider participation, input, acceptance and usage of practice guidelines are essential if the guidelines are to be efficacious in improving clinical care.

Anthem has developed several evidence-based practice guidelines. The guidelines are available on the anthem.com Web site through the Connecticut Provider page.

**Provider Advisory Panels**

**Regional Quality Steering Committee (RQSC)**

The Anthem Northeast Regional Quality Steering Committee is a collaborative interdisciplinary group, serving as the stewards and advocates for quality of care and service in the Anthem Northeast Region (Connecticut, Maine and New Hampshire). The Committee meets monthly and provides strategic direction and oversight for all aspects of quality management for the Anthem Northeast Region, providing the “face” of quality both internally and externally.

Local external advisory committees interface with the RQSC to effectively provide external input into internal programming. Local service and operations committees will also interface with the RQSC in order to coordinate on service quality improvement activities related to Quality Management. Other committees (e.g. Medical Policy and Quality Improvement Council and workgroups (e.g. Delegation Oversight and Corporate P&T) report into the regional committee.
Behavioral Health Advisory Committee

The Anthem Northeast Behavioral Health Advisory Committee is sponsored by Anthem Blue Cross and Blue Shield and Anthem Behavioral Health. The Committee meets on a regular basis to share knowledge and recommendations related to behavioral health issues, and will serve as an important link between the behavioral health provider community, Anthem Blue Cross and Blue Shield and Anthem Behavioral Health, providing a forum for the sharing of best practices, ideas, issues and concerns.

Providers serving on the Committee represent a wide-range of behavioral health physicians and practitioners (including psychiatrists, psychologists, clinical social workers and APRNs) from both individual and group practices, from across the state.
13. INSTITUTIONAL NETWORKS

Table of Contents

Participating General Hospitals** .....................................................................................................2

Mental Health and Chemical Dependency Networks .................................................................3

Inpatient Transitional Care Services ..........................................................................................3
  Transitional Care Eligibility ..................................................................................................3

Urgent Care Facilities ................................................................................................................4

Organ Transplant Services .........................................................................................................5

Facility Code Listings ..................................................................................................................6

Subacute Care Centers ................................................................................................................7
  Inpatient Subacute Care Criteria ..........................................................................................7

Skilled Nursing Facility Network ...............................................................................................13
  Inpatient Skilled Nursing (SNF) Criteria ............................................................................13

Acute (Comprehensive) Rehabilitation Care ..........................................................................16
  Acute (Comprehensive) Rehabilitation Criteria .................................................................17

Utilization review criteria are used in determining the member’s contract benefits on the date the services are rendered. Contract language, including definitions and specific inclusions/exclusions, as well as state and federal law, are considered in determining eligibility for coverage. The criteria are used only with the judgment of a qualified clinical professional with the ability to take into account the individual circumstances of each member’s case.

The guidelines which appear in this section constitute Anthem’s modifications to the Medicare Guidelines. Medicare has neither reviewed nor approved the modified material. Any statement to the contrary or association of the modified material with Medicare is strictly prohibited. CPT © American Medical Association. Anthem Midwest Medical Review & Utilization Management Criteria © Anthem Blue Cross and Blue Shield. No part of this publication may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written permission from an officer of Anthem Blue Cross and Blue Shield.
## Participating General Hospitals**

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Century Preferred, Century 90*</th>
<th>BlueCare Health Plan+</th>
</tr>
</thead>
<tbody>
<tr>
<td>William Backus Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Baystate Med. Ctr., Springfield, MA</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bradley Memorial Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bridgeport Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bristol Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Connecticut Children’s Med. Ctr.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Danbury Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day Kimball Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Greenwich Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Griffin Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Harrington Mem., Southbridge, MA</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Hartford Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hospital of Saint Raphael</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hubbard Reg. Hosp., Webster, MA</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Charlotte Hungerford Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Johnson Memorial Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lawrence and Memorial Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Manchester Memorial Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Middlesex Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mid-State Medical Center</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Milford Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Britain General Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Milford Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Norwalk Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rockville General Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>St. Francis Hospital &amp; Medical Ctr.</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Saint Mary’s Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>St. Vincent’s Medical Center</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Sharon Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Stamford Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>John Dempsey Hospital (UCONN)</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Westerly Hospital, Westerly, RI</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>Windham Comm. Memor. Hospital</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Yale-New Haven Hospital</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* Including Century Preferred Comp and FEP Standard Option.
+ Including State BlueCare, State Preferred and FEP Basic Option.

** The participating general hospitals listed above may not be participating transplant facilities.
Mental Health and Chemical Dependency Networks
Free Standing

<table>
<thead>
<tr>
<th>Institution Name</th>
<th>Mental Health Facility</th>
<th>Chemical Dependency Facility</th>
<th>Century Preferred, Century 90*</th>
<th>BlueCare Health Plan+</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Recovery Centers</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Alliance Treatment Center</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Arms Acres (Carmel, NY)</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Change name to: LMG Programs</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hall-Brooke Foundation</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Natchaug Hospital</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Rushford Treatment Center</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Silver Hill Hospital</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Stonington Institute</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* Including Century Preferred Comp and FEP Standard Option.
+ Including FEP Basic Option.

Inpatient Transitional Care Services

Anthem has contracted with hospitals across the state to provide members of BlueCare Health Plan, Century Preferred, State Preferred and Century 90 programs with Managed Care with "transitional care services" during inpatient hospital stays. These services are available for approved inpatient days where the level of service required is not acute, but the patient cannot yet be discharged to their home with home care, or to an alternative care facility, or there is a delay in the provision of acute services.

Prior Authorization of Transitional Care Services

Prior authorization is required for all transitional care days, and may be obtained by calling our Utilization Management Department at (800) 238-2227 (toll free in Conn.), or (800) 248-2227 (out-of-state).

Transitional Care Eligibility

Situations where transitional care would be appropriate include, but are not limited to:

- Waiting for patient’s placement into a network alternative care facility due to lack of bed availability (maximum two days).
- Clinical indications exist to postpone cardiac services/procedures (e.g. stress tests, cardiac catheterizations, PTCA).
- Dialysis patients with complex medical needs.
- Radiation therapy patients with complex medical needs.
- Short term rehabilitation patients (generally 1-2 days).
- Patients requiring IV heparin (that which cannot be administered in a subacute facility).
- Patients requiring IV infusion therapy (that which cannot be administered in the home).
- Patients requiring post surgical care monitoring (plastic and reconstructive, vascular)
- Transfers from another facility for procedures, with delay in performing the procedure due to clinical, not administrative reasons.
Exemptions from transitional care are:

- Hospice care
- Acute rehabilitation

### Hospitals Providing Transitional Care Services

<table>
<thead>
<tr>
<th>Hospital</th>
<th>BlueCare (incl. State BlueCare)</th>
<th>Century Preferred</th>
<th>State Preferred</th>
<th>Century 90 Programs</th>
</tr>
</thead>
<tbody>
<tr>
<td>W. Backus</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bridgeport</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Bristol</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>CCMC*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Day Kimball</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Griffin</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Hartford</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Charlotte Hungerford</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospital of St. Raphael’s</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>John Dempsey Johnson Memorial</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Lawrence and Memorial Memorial</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Milford</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>New Milford</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>St. Francis</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>St. Mary’s</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Waterbury</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Windham Comm.Hosp.</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

* Connecticut Children’s Medical Center

### Urgent Care Facilities

Participating urgent care facilities provide members of BlueCare Health Plan, Century Preferred and State Preferred access to a comprehensive, hospital-based urgent care facility network for urgent care 24 hours a day, seven days a week. The facilities provide:

- **Triage service** - Medical professionals determine if the patient requires emergency or urgent care. Access to the emergency room is available when medically necessary.
- **Extended hours of service** – available to members at any time.
- **Shorter wait times** – 90 percent of members must be treated within 60 minutes.
- **Access to hospital facilities** - available hospital equipment, technologies and other on-site ancillary services including x-ray, laboratory and pharmacy.
- **Quality monitoring** via provider audits and satisfaction surveys.

Members must access urgent care from one of the following participating urgent care facilities to be eligible for in-network coverage rendered by other than the PCP.
Participating Urgent Care Centers

<table>
<thead>
<tr>
<th>Participating Care Centers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bridgeport Bridgeport Hospital</td>
</tr>
<tr>
<td>St. Vincent’s Hospital</td>
</tr>
<tr>
<td>Bristol Bristol Hospital</td>
</tr>
<tr>
<td>Danbury Danbury Hospital</td>
</tr>
<tr>
<td>Derby Griffin Hospital</td>
</tr>
<tr>
<td>Essex Shoreline Medical Center (Department of Middlesex Hospital)</td>
</tr>
<tr>
<td>Farmington UCONN/John Dempsey Hospital</td>
</tr>
<tr>
<td>Hartford Hartford Hospital</td>
</tr>
<tr>
<td>St. Francis Hospital &amp; Medical Center</td>
</tr>
<tr>
<td>St. Francis Hospital &amp; Medical Center, Mount Sinai Campus</td>
</tr>
<tr>
<td>Manchester Manchester Memorial Hospital</td>
</tr>
<tr>
<td>Marlborough Marlborough Medical Center (Department of Middlesex Hospital)</td>
</tr>
<tr>
<td>Meriden Mid-State Medical Center</td>
</tr>
<tr>
<td>Middletown Middlesex Hospital</td>
</tr>
<tr>
<td>Milford Milford Hospital</td>
</tr>
<tr>
<td>New Britain New Britain General Hospital</td>
</tr>
<tr>
<td>New Haven Hospital of Saint Raphael</td>
</tr>
<tr>
<td>Yale-New Haven Hospital</td>
</tr>
<tr>
<td>New London Lawrence &amp; Memorial Hospital</td>
</tr>
<tr>
<td>Pequot Health Center (Department of Lawrence &amp; Memorial Hospital)</td>
</tr>
<tr>
<td>New Milford New Milford Hospital</td>
</tr>
<tr>
<td>Norwalk Norwalk Hospital</td>
</tr>
<tr>
<td>Norwich William W. Backus Hospital</td>
</tr>
<tr>
<td>Putnam Day Kimball Hospital</td>
</tr>
<tr>
<td>Rockville Rockville Hospital</td>
</tr>
<tr>
<td>Sharon Sharon Hospital</td>
</tr>
<tr>
<td>Southington Bradley Memorial Hospital</td>
</tr>
<tr>
<td>Stafford Springs Johnson Memorial Hospital</td>
</tr>
<tr>
<td>Torrington Charlotte Hungerford Hospital</td>
</tr>
<tr>
<td>Waterbury St. Mary’s Hospital</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
</tr>
<tr>
<td>Windham Windham Community Memorial Hospital</td>
</tr>
<tr>
<td>Winsted Winsted Health Center (Div. of Charlotte Hungerford Hospital)</td>
</tr>
<tr>
<td>Westerly, RI Westerly Hospital (BlueCare, State BlueCare and State Preferred only)</td>
</tr>
</tbody>
</table>

Organ Transplant Services

Anthem participates in the Blue Quality Centers for Transplant network, a cooperative network offered by the Blue Cross and Blue Shield Association and Blue Cross/Blue Shield plans in the United States. Our network provides members access to well-known transplant facilities throughout the country and includes the following types of transplant services:

- Heart
- Lung
- Combination Heart Bilateral Lung
- Kidney
- Liver (adult or child)
- Pancreas
- Allogeneic and Autologous Bone Marrow/Peripheral Stem Cell
Please note:
* Use of a designated transplant facility is not required for independent kidney transplantation; however, the appropriate prior authorization is required.
* Not every designated hospital performs each of the specified procedures.

Prior Authorization
As soon as a potential transplant patient is identified, the physician must contact the Transplant Unit of our Utilization Management Department to request prior authorization. A nurse case manager will verify coverage eligibility and confirm that the member meets the criteria of the program. In all cases, transplant services are subject to the terms, conditions, limitations and exclusions of the member’s coverage document.

To request prior authorization or for further information contact the Anthem Blue Cross and Blue Shield Transplant Unit:
☎ (800) 255-0881

The Benefit Programs
(For information on transplants for members of the BlueCare Family Plan, refer to that plan’s specific policies and procedures manual):

**HMO PLANS**
Members of the following programs who require transplantation must access treatment from our designated network of facilities to be eligible for coverage. Prior authorization of transplant services is required:

- All BlueCare Health Plan programs - including point-of-service plans.

**IMPORTANT:** Members of the above programs who choose to go to a facility that is not designated or approved by Anthem to provide human organ and tissue transplant services will not be eligible for coverage.

**PPO PLANS**
Members of the following programs who require transplantation must access treatment from our designated network of transplant facilities to be eligible for coverage for in-network coverage. Prior authorization of transplant services is required:

- Century Preferred / Century Preferred Comp

**IMPORTANT:** Members of the above programs who choose to go to a facility that is not designated or approved by Anthem to provide human organ and tissue transplant services will be responsible for significant cost sharing requirements including deductibles and coinsurance.

Facility Code Listings
See Appendix C for Facility Code Listings; Hospital, Surgical Center, Skilled Nursing Facility.
Subacute Care Centers

Anthem Blue Cross and Blue Shield has contracted with a network of freestanding subacute care centers to provide care for members who require short-term rehabilitation and recovery. This network is available to members of the Anthem BlueCare Health Plan, State BlueCare, State Preferred, Century 90 and Century Preferred programs with Managed Benefits, as well as Federal Employee Program and National Account members. Please refer to our provider directory for an updated listing. Our directory can be found online at anthem.com.

Prior authorization is required on all inpatient subacute admissions and may be obtained by calling our Utilization Management Department at (800) 238-2227. If it is determined that subacute care is eligible for coverage for the member, our staff will work with the hospital personnel to facilitate referrals to participating subacute facilities.

The following criteria for coverage eligibility will assist you when admitting patients to participating freestanding subacute care centers. If all criteria are met, services are eligible for coverage for a member who is admitted directly from home, from a skilled nursing facility or from an acute care facility.

**INPATIENT SUBACUTE CARE CRITERIA**

**I. Definitions**

These criteria are utilized to determine the Medical Necessity of a Subacute Care admission and continued stay. Reference should be made to the applicable Subscriber Agreement, Health Care Benefit Plan or other coverage document for any and all definitions of the terms referred to in the above mentioned Criteria.

Confirmation of the Medical Necessity of any or all proposed services does not guarantee payment of benefits, rather it will only serve to confirm the Medical Necessity of the proposed services. Payment of benefits is subject to the terms, limitations and exclusions of the member’s Subscriber Agreement, Health Care Benefit Plan or other coverage document.

**II. Criteria**

**A. Introduction**

Subacute care is a distinct, complex and comprehensive form of inpatient care that is designed to offer patients a level of care which is not as intensive as acute care (including Acute (Comprehensive) Rehabilitation Care), but is more intensive than Home Care. Subacute care is designed to be short-term and could be categorized as either Medical and/or Rehabilitative, or a combination of both. The following is a definition of Subacute care from the National Subacute Care Association:

“Subacute care is a comprehensive, cost effective inpatient level of care for patients who:

a) have had an acute event resulting from injury, illness or exacerbation, or a disease process.

b) have a determined course of treatment, and though stable, require diagnostic or invasive procedures, but not intensive procedures requiring an acute level of care.

The severity of the patient’s condition requires:

a) active physician direction with frequent on-site visits,

b) professional nursing care,

c) significant ancillary services,

d) an outcomes-focused interdisciplinary approach utilizing a professional team,

e) complex medical and/or rehabilitative care.
Typically short term, subacute care is designed to return the patient to the community or transition them to a lower level of care. *

*Source: NSCA, National Subacute Care Association Definition of Subacute Care as developed and approved by the NSCA Board of Directors, June 27, 1996. NSCA, 7315 Wisconsin Avenue, suite 424 East, Bethesda, MD  20814

B. General Criteria

In determining Medical Necessity for eligibility for Subacute benefits, all of the following criteria must be met:

a) Subacute care must be rendered immediately prior to, after or instead of acute hospitalization or inpatient acute rehabilitation level of care.

b) Subacute care must treat one or more specific, active, medically complex, medically unstable conditions, or provide technically complex treatments intended to be rehabilitative and restorative.

c) The subacute care program must provide the services of an interdisciplinary team with the expertise to access, treat, monitor and evaluate all required services. These should include, but not be limited to:
   - Skilled Care rendered by RNs or LPNs under the direction of an RN
   - Physical Therapy
   - Occupational Therapy
   - Speech Therapy
   - Respiratory Therapy
   - Medical Social Services
   - Nutrition Counseling
   - IV Therapy
   - Wound Management
   - Case Management
   - Routine DME

d) The intensity and combination of services cannot be provided in any other inpatient setting, home care or outpatient level of care.

e) The patient’s care must be under the direction of a physician who monitors the patient’s progress at least twice a week but is available seven days a week.

f) Services are anticipated to be short term and stated as such in the patient’s treatment plan.

g) The patient must be capable of active participation in the proposed therapies.

C. Rehabilitative Care Services: Specific Evaluation Criteria

In addition to meeting all General Criteria specified in Part B above, all members admitted to a Subacute Care Facility for Rehabilitative Care Services must be evaluated in the following Psychosocial and Functional areas. Initial evaluations must be made prior to admission. Treatment Plans, Short Term Goals and Long Term Goals are expected to be updated two times per week and must include Discharge Planning updated and Levels of Expected Maximum Functional Ability.

Indicators:

1) Psychosocial indicators:
   a) Cognitive Status
      - Awareness
      - Safe decision making ability
   b) Caregiver Status
   c) Past Medical History
   d) Current Medical Conditions
   e) Current medications including the patients response to medications
2) Functional indicators:
   a) Transfers
      - Supine/Sit
      - Sit/Stand
      - Floor/Stand
   b) Bed Mobility
      - Supine/Prone
      - Roll Right
      - Roll Left
   c) Supine/Sit
   d) Bathroom Mobility
      - Stand/Commode
      - Access to
   e) Ambulatory
      - Assist Device(s) (provide a list)
      - Assist level
      - Distance
      - Safety
   f) ADL's
      - Don/Doff Clothing/Shoes
      - Feeding/Cook
      - Meal Preparation
      - Reach
      - Lift
      - Carry
      - Personal Hygiene
   g) Home Environment
      - Accessibility (stairs/doors)
      - Internal Environment (mobility)
      - Adaptations needed
      - Adaptations done
      - Access to emergency help
   h) Orthopedic and/or Neurological
      - ROM
      - Strength
      - Joint Stability/Mobility
      - Intervertebral Mobility
      - Special Testing
      - Reflexes/Abnormal Reflexes
      - Sensation
      - Myotomal Strength
      - Talan Changes
   i) Functional Capacity/Endurance:
      - Reach
      - Lift
      - Carry
      - Push/Pull
   j) Gait
      - Distance
      - Deviations
   k) Assist Devices
   l) Manual Muscle Testing
      - Assessment
Evaluation scales:

1) Cognition:
   a) No awareness, inability to make decisions
   b) Sporadic awareness, safety decisions
   c) Occasional awareness and safe decision making
   d) Intermittent awareness and safe decision making
   e) Consistent awareness and safe decision making
   f) Full awareness and safe decision making

   - Sporadic <10 percent of the time
   - Occasional 10-25 percent of the time
   - Intermittent 25-50 percent of the time
   - Constant 50-75 percent of the time
   - Fully 75-100 percent of the time

2) Care Giver Status:
   a) No assistance available
   b) Sporadic assistance available/single care giver
   c) Occasional assistance available/single-multiple care givers
   d) Constant assistance available/single-multiple care givers
   e) 24 hour/seven days/week multiple support systems

3) Current Medications:
   a) Unable to self medicate/totally dependent
   b) Sporadic self medication/constant supervision
   c) Occasional assistance available/single-multiple care givers
   d) Intermittent assistance available/single-multiple care givers
   e) 24 hour/seven days/week multiple support system

   - Sporadic <10 percent of the time
   - Occasional 10-25 percent of the time
   - Intermittent 25-50 percent of the time
   - Constant 50-75 percent of the time
   - Fully 75-100 percent of the time

4) Functional including transfers, bed mobility, bathroom mobility, ambulation, ADL’s and home environment:
   a) No independent ability (maximum assist 1-2)
   b) Moderate assist of 1-2 with continuous cueing
   c) Moderate assist of 1-2 with moderate cueing
   d) Supervision only
   e) Independent

5) ROM:
   a) No motion available
   b) 50 percent ROM gravity eliminated
   c) 100 percent ROM gravity eliminated
   d) 50 percent ROM against gravity
   e) 75 percent ROM against gravity
   f) Full ROM against gravity

6) Strength:
   a) No movement/gravity eliminated
   b) One half ROM/gravity eliminated/no weight
   c) Full ROM/gravity eliminated with moderate weight
   d) Full ROM/against gravity/no weight
   e) Full ROM against gravity/moderate weight
   f) Normal strength against gravity

7) Tone/Reflexes:
   a) Flaccid/flaccid
   b) Moderate hypotonicity/moderate hyporeflexia
   c) Minimal hypotonicity/minimal hyporeflexia
   d) Normal tone/reflex
   e) Moderate hypertonicity/moderate hyperreflexia
f) Maximal hypertonicity/maximal hyperreflexia

8) Soft Tissue:
   a) Significant pitting edema/mark ed myofascial restrictions
   b) Moderate pitting edema/significant myofascial restrictions
   c) Minimal pitting edema/mark ed non-pitting edema/moderate myofascial restrictions
   d) Moderate non-pitting edema/minimal myofascial restrictions
   e) WNL

9) Functional Capacity:
   a) Unable to tolerate any activity/no endurance
   b) Tolerates minimal activity with poor endurance/recovery
   c) Tolerates minimal activity with fair endurance/recovery
   d) Tolerates moderate activity with fair endurance and recovery
   e) Tolerates moderate activity with good endurance and recovery
   f) Tolerates activity with normal endurance and quick recovery

10) Ambulation:
    a) Unable to ambulate
    b) Ambulate 25-50 feet/2-3 trials with moderate/great exertion
    c) Ambulate 50-100 feet/2-3 trials with moderate exertion
    d) Ambulate 50-100 feet/multiple trials/minimal exertion
    e) Ambulate 100-250 feet/multiple trials without exertion
    f) Ambulates > 250 feet multiple trials without exertion

D. Routine Subacute Services Levels of Care

There are four distinct Subacute levels of care defined by the amount of required services. These services may be skilled nursing and/or rehabilitative services. The number of units of Rehabilitation Therapy or hours/day of skilled nursing services will determine the level of care.

Level I
2.5 to 3.0 hours of skilled nursing services per day and/or at least four units of Rehabilitation Therapy at least five times per week. Other services commonly performed at this level may include, but are not limited to:

- Social services
- Medical supplies
- Routine pharmacy medications
- Oxygen therapy and supplies
- DME for inpatient use, such as crutches, cane, walker
- Routine laboratory
- Diagnostic radiology
- EKG/EEG

Level II
3.0 to 4.0 hours of skilled nursing services per day and/or at least six units of Rehabilitation Therapy at least five times per week. Other services commonly performed at this level may include, but are not limited to:

- Enteral feedings, including equipment and supplies
- Intermittent IV services (i.e.: Heparin Locks)
- Isolation cases
- Stage I and/or Stage II decubitus care requiring the application of prescription medications and/or dressings requiring sterile techniques
- Chemotherapy, intravenous and/or by mouth
- Wound care and supplies
Level III
4.0 to 6.0 hours of skilled nursing services per day and/or at least ten units of rehabilitation therapy at least five times per week. Other services commonly performed at this level may include, but are not limited to:

- Stage III and IV Decubitus Care requiring the application of prescription medications and/or dressings requiring sterile techniques
- Tracheostomy patients
- Chronic/Continuous Ambulatory Peritoneal dialysis, including equipment and supplies
- Complex wound care
- Multiple orthopedic injuries
- High level respiratory care requiring complex treatment including oxygen, monitoring and temporary assistive devices
- Continuous intravenous therapy
- Whirlpool treatments

Level IV
6.0 to 8.0 hours of skilled nursing services per day and/or at least 12 units of rehabilitation therapy at least five times per week. Other services commonly performed at this level may include, but are not limited to:

- Parenteral pain management
- Tracheostomy care
- Ventilator weaning program

III. Termination of Subacute Care Services

The member will no longer be eligible for coverage for Subacute Care Services when the treatment or services can be rendered safely and reasonably at a lesser level of care, or the member requires a more intensive level of care. Examples may include but are not limited to:

- Inpatient Acute Hospital
- Inpatient Acute Rehabilitation
- Skilled Level of Care
- Home Care services
- Outpatient services

In addition, the member will no longer be eligible for coverage when any one of the following apply to the member’s case:

1. The patient’s needs have become custodial.
2. There is no documented progress towards treatment goals during any one week period.
3. There is a lack of a consistent individualized therapy program.
4. The patient has refused to participate in the recommended treatment plan.
5. The patient’s activities or behavior prevents attainment of a successful outcome.
6. The patient’s primary need becomes psychiatric in nature.
7. The patient has signed himself out “Against Medical Advice.”
8. The patient has only one skilled need.
9. When the discharge to a lesser level of care is documented as appropriate and safe, but there were delays in formulating the discharge plan.
10. The established goals are not realistic or appropriate.
11. There is no documentation over a one week period that a physician has evaluated and/or has conferred with the staff/patient about the prescribed treatment.
Skilled Nursing Facility Network

A network of skilled nursing facilities is available to members of the Anthem BlueCare Health Plan, State BlueCare, State Preferred, Century 90 and Century Preferred programs with Managed Benefits, as well as Federal Employee Program and National Accounts members. This network provides another step in our commitment to coordinate appropriate, cost effective, alternative levels of care to members, while assuring a high level of quality and patient satisfaction. Members must access care from a participating Anthem facility to be eligible for in-network benefits.

Participating facilities must be accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO). We have currently contracted with a wide network of skilled nursing facilities throughout our service area, and will continue to develop this network and add additional facilities. Please refer to our provider directory for an updated listing. Our directory can be found online at anthem.com.

Prior authorization is required on all skilled nursing admissions and can be coordinated with the hospital discharge planner and/or obtained by calling our Utilization Management Department at (800) 238-2227. Our utilization review nurses will work with the hospital personnel and/or the member’s physician to facilitate referrals to participating skilled nursing facilities.

The following criteria, reviewed and approved by physicians across Connecticut represented on our consultant panels, will assist you when admitting patients to participating skilled nursing facilities. If all criteria are met, services are eligible for coverage for a member who is admitted directly from home, from a subacute care facility, or from an acute care facility. However, Medicare admission guidelines will apply if Medicare is the primary insurer.

INPATIENT SKILLED NURSING (SNF) CRITERIA

These criteria are utilized to determine the Medical Necessity of a Skilled Nursing Facility (SNF) admission and continued stay. Reference should be made to the applicable Subscriber Agreement, Health Care Benefit Plan or other coverage document for any and all definitions of the terms referred to in the above mentioned Criteria.

Confirmation of the Medical Necessity of any or all proposed services does not guarantee payment of benefits, rather it will only serve to confirm the Medical Necessity of the proposed services. Payment of benefits is subject to the terms, limitations and exclusions of the member’s Subscriber Agreement, Health Care Benefit Plan or other coverage document.

I. Definitions:

A skilled nursing facility (SNF) is an institution (or a distinct part of an institution), such as a skilled nursing home, that mainly provides inpatient skilled nursing and related services to members requiring convalescent and rehabilitative care. Such care is given by or under the supervision of physicians. A skilled nursing facility is not a place that provides custodial, ambulatory, or part-time care, or treatment for mental health disorders, substance abuse or pulmonary tuberculosis. The facility or program must be licensed, certified, or otherwise authorized, pursuant to the laws of the state in which it is situated, as a skilled nursing home and approved by Anthem to provide the skilled nursing services covered by the member’s benefit plan.

Skilled nursing services are furnished pursuant to physician orders, and require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapist, and speech pathologists or audiologists. These services must be provided directly by or under the general supervision of these skilled nursing or
skilled rehabilitation personnel to assure the safety of the member and to achieve the medically desired result.

**Custodial care:**
- a. Custodial care is that care which is primarily for the purpose of assisting the insured in the activities of daily living, or in meeting personal rather than medical needs, which is not specific therapy for a sickness or injury and is not skilled care.
- b. Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding by utensil, tube, or gastrostomy, oral hygiene, ordinary skin and nail care, catheter care, suctioning, and using the toilet, enemas; and preparation of special diets, and supervision of medication that usually can be self-administered.
- c. Custodial care essentially is personal care that does not require the continuing attention of trained medical or paramedical personnel.
- d. In determining whether a person is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation, or rehabilitation potential.

**II. Criteria**

**A. Introduction**

Inpatient skilled nursing is a level of care that is designed to provide a member the opportunity to receive daily skilled services that can only be provided in an inpatient setting. This level of care is found along the continuum of care between inpatient Subacute Care and Home Care Services. The required services must be ordered by a physician and requires the skills of a licensed professional i.e. nurse or physical therapist. These skilled services must be required on a daily basis, or in the case of a physical therapist, at least five times a week. In order to be eligible for benefits for services received in a skilled nursing facility, all of the following criteria must be met:

**B. General Criteria**

When a prior authorization request for skilled nursing facility admission is received via phone, fax or mail, the Utilization Management nurse will verify the following information:

1. Membership
2. Effective Dates
3. Type of plan and benefits available for skilled nursing facility
4. Coordination of Benefits

**Section I**

**A. When assessing the medical necessity for admission to a skilled nursing facility (SNF) setting, all of the following requirements must be met:**

1. The member requires skilled nursing services that must be performed by or under the supervision of professional or technical personnel;
2. The member requires these skilled services on a daily basis;
3. The daily skilled services can be provided only on an inpatient basis in a skilled nursing facility (SNF) setting;
4. SNF settings must be furnished pursuant to a physician's orders and be reasonable and necessary for the treatment of a member's illness of injury, i.e., be consistent with the nature and severity of the individual's illness or injury, his particular medical needs, and accepted standards of medical practice;
5. Admission to a skilled nursing facility (SNF) for skilled nursing services and/or rehabilitation services must include development, management, and evaluation of a complicated or extensive plan of care as follows:
   a. The involvement of skilled nursing personnel is required to meet the member's medical needs, promote recovery, and ensure medical safety (in terms of the member's physical or mental condition);
   b. There must be a significant probability that complications would arise without skilled supervision of the treatment plan by a licensed nurse;
c. Care plans must include realistic nursing goals and objectives for the member, discharge plans, and the planned interventions by the nursing staff to meet those goals and objectives;
d. Updated care plans must document the outcome of the planned interventions;
e. There must be daily documentation of the member's progress and/or complications.

B. In addition to the general requirements above, the member's condition must require one or more of the following defined settings below on a daily basis:

1. Observation, assessment, and monitoring of a complicated or unstable condition:
   a. The unstable condition of the member must require the skills of a licensed nurse or rehabilitation personnel in order to identify and evaluate the member's need for possible modification of the treatment plan or initiation of additional medical procedures.
   b. There must be a high likelihood of a change in a member's condition due to complications or further exacerbations.
   c. Daily nursing notes must give evidence of the member's condition and indicate the results of monitoring.
   d. Documentation must indicate the member's condition and indicate the results of monitoring.

2. Complex teaching services to the member and/or caregiver requiring a 24-hour SNF setting vs. intermittent home health care setting.
   a. The teaching itself is the skilled service. The activity being taught may or may not be considered skilled.
   b. Documentation should include the reasons why the teaching was not completed in the hospital, as well as the member's or caregiver's capability of compliance.

3. Complex medication regimen:
   a. The member must have a complex range of new medications (including p.o. medications) following a hospitalization where there is a high probability of adverse reactions and/or a need for changes in the dosage or type of medication.
   b. Documentation required to authorize initial admission and extensions must include the member's unstable condition, medication changes, and continuing probability of complications.

4. Initiation of tube feedings
   a. Nasogastric tube and percutaneous tubes (including gastrostomy and jejunostomy tubes).

5. Actively weaning of ventilator dependent members
   a. These members are considered skilled due to their complex care.

6. Wound Care (including decubitus ulcers)
   Skilled nursing facility placement solely for the purpose of wound care should be rare.
   ALL of the following criteria must be met:
   a. Wound care must be ordered by a physician
   b. The member must require extensive wound care (e.g., packing, debridement, and/or irrigation of multiple stage II, or stage III, or stage IV wounds).
   c. Skilled observation and assessment of a wound must be documented daily and should reflect any changes in wound status to support the medical necessity for continued observation.

7. Respiratory Therapy (RT): The need for respiratory therapy, either by a nurse or by a respiratory therapist, does not alone qualify a member for skilled nursing facility (SNF) care.

Section II

A skilled nursing facility (SNF) setting is not medically indicated for the following conditions or services:
1. Services do not meet the adequate reason for the skilled nursing facility setting set forth above.
2. The services are provided by a family member or another non-medical person. When a
Anthem has contracted with a network of freestanding Acute (Comprehensive) Rehabilitation facilities intended to provide a 24-hour program of coordinated and integrated health care services. This network is available to members of the Anthem Century 90 and Century Preferred programs with Managed Benefits, as well as BlueCare Health Plan, State BlueCare, State Preferred, Federal Employee Program and National Accounts members. Please refer to our provider directory for an updated listing. Our directory can be found online at anthem.com.

Prior authorization is required on all acute (comprehensive) rehabilitation care admissions and can be coordinated with the hospital discharge planner and/or obtained by calling our Utilization Management Department at (800) 238-2227. If it is determined that this level of care is eligible for

Acute (Comprehensive) Rehabilitation Care

service can be safely and effectively performed (or self-administered) by the average non-medical person without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service.

3. Services are for custodial care.
4. Services which are solely performed to preserve the present level of function or prevent regression of functions for an illness, injury or condition which is resolved or stable.
5. Physical medicine therapy or rehabilitation services in which there is not a practical improvement in the level of functioning within a reasonable period of time.

The following services are examples that do not require the skills of licensed nurse or rehabilitation personnel, and therefore are not considered to be medically necessary in the skilled nursing facility setting, unless there is documentation of co-morbidities and complications that require individual consideration:

1. Routine services directed toward the prevention of injury or illness
2. Routine or maintenance medication administration. SNF admissions solely for the administration of routine or maintenance medications, including daily IV, IM, and SQ medications are not considered skilled. Parenteral medication administration in medically stable members is most often managed in the home setting by a home health or home infusion therapy provider.
3. Care solely for the administration of oxygen, IPPB treatments and nebulizer treatments
4. Heat treatments: whirlpool, paraffin baths and heat lamps
5. Routine enteral feedings
6. Routine colostomy care
7. Ongoing intermittent straight catheterization for chronic conditions
8. Custodial care by an LPN or RN
9. Emotional support and/or counseling
10. Suctioning of the nasopharynx or nasotrachea. Suctioning daily or PRN less frequently than every four hours is not considered skilled.
11. Administration of suppositories and/or enema
12. Routine foot and nail care
13. Medically stable vent care
14. Urinary catheters - The presence of a stable indwelling or suprapubic catheter, the need for routine intermittent straight catheterization, catheter replacement or routine catheter irrigation does not qualify a member for SNF placement unless other skilled needs exist.
15. Heat treatment - wet or dry
   a. Whirlpool baths, paraffin baths, or heat lamp treatments do not qualify a member for care in a SNF.
   b. There may be a rare instance when a severely compromised member with desensitizing neuropathies or severe burns requires skilled observation during the above treatments. These cases are to be reviewed on an individual consideration basis. Documentation must support the medical necessity for such observation.

**Any situation that does not meet the above criteria requires physician review.**
coverage for the member, our staff will work with the hospital personnel to facilitate referrals to participating facilities.

The following criteria for coverage eligibility will assist you when admitting patients to participating acute (comprehensive) rehabilitation care centers. If all criteria are met, services are eligible for coverage for a member who is admitted directly from home, from a skilled nursing facility or from an acute care facility.

**ACUTE (COMPREHENSIVE) REHABILITATION CRITERIA**

**I. Definitions**

These criteria are utilized to determine the Medical Necessity of an Acute (Comprehensive) Rehabilitation admission and continued stay. Reference should be made to the applicable Subscriber Agreement, Health Care Benefit Plan or other coverage document for any and all definitions of the terms referred to in the above mentioned Criteria.

Confirmation of the Medical Necessity of any or all proposed services does not guarantee payment of benefits, rather it will only serve to confirm the Medical Necessity of the proposed services. Payment of benefits is subject to the terms, limitations and exclusions of the member’s Subscriber Agreement, Health Care Benefit Plan or other coverage document.

**II. Criteria**

**A. Introduction**

Acute Inpatient Rehabilitation refers to a rehabilitation program provided in an acute care institution (or a distinct part of an institution) which provides an intensive multidisciplinary, coordinated team approach to rehabilitation services for the injured or disabled to restore lost function following an acute illness or accidental injury. The aim of the treatment is achieving the maximum level of function possible.

Rehabilitative care in an acute inpatient setting is appropriate for members who require a more coordinated, intensive program of multiple services than is generally found in a SNF or outpatient setting. Members are likely to require an inpatient level of rehabilitation if they have one or more conditions requiring intensive and multidisciplinary rehabilitation care, or a medical complication in addition to their primary condition which requires the continuing availability of a physician to ensure safe and effective treatment.

Comprehensive inpatient rehabilitation programs offer a wide range of therapeutic services provided by registered, certified, licensed, or degreed professionals utilizing a multidisciplinary, goal oriented, team approach with treatment plans designed specifically for the individual member’s needs. Acute inpatient rehabilitation programs must follow a multidisciplinary, coordinated team approach by providing services not available in the outpatient setting or skilled nursing facilities.

**B. General Criteria**

Inpatient rehabilitation may be considered medically necessary for members meeting ALL of the following criteria:

1. The member has a condition that has resulted in a significant decrease in functional ability.
2. The member is medically stable.
3. There is an expectation for significant practical improvement in a reasonable period of time.
4. The member requires multidisciplinary comprehensive rehab services as part of team program that cannot be achieved at a less intensive level of care.
5. The member has sufficient cognitive and physical capacity to participate in a comprehensive inpatient rehabilitation program and has not previously been in a rehabilitation program for this episode of care.
6. Functional/measurable goals are identified within 24 hours of admission and updated in order to
facilitate a safe transition to a less comprehensive setting/home. Documentation of objective outcome measures of program and goals of continued treatment should be verified in weekly team conference notes for review.

7. Discharge plan to home.

Refer to Definitions below (#1-5) for detailed description of Inpatient Rehabilitation listed above that may be considered medically necessary.

Discharge from inpatient rehabilitation should occur when:

1. There is documentation of the member's achievement of stated goals
2. Daily multidisciplinary therapy is no longer indicated
3. Medical complications preclude intensive rehabilitation
4. The member's functional status has remained unchanged or additional functional improvement appears unlikely within a reasonable time frame (seven to 14 days); OR The level of rehabilitative/restorative care required could be safely rendered in an alternate, less intensive setting; e.g., outpatient, SNF, or home health.

The following services are generally NOT considered acute inpatient rehabilitation:

1. Coma stimulation.
2. The restorative needs do not require multidisciplinary, coordinated team approach at the intensity of acute rehabilitation.
3. Multidisciplinary therapies lasting less than three hours a day.
4. Cognitive retraining, behavioral management, or community re-entry not related to safety skills training and/or problem-solving techniques provided in conjunction with the multidisciplinary team. This should not be interpreted as needing to permit continued inpatient care for all safety issues.
5. Member is not able to actively participate in an acute rehab program because of inadequate cognitive capabilities or for medical reasons.
6. Direct admission from home.

Definitions:
Detailed description of inpatient rehabilitation may be considered medically necessary for members meeting ALL of the following criteria:

1. The member has a condition that has resulted in a significant decrease in functional ability.

This may be the result of a stroke/CVA, closed head or traumatic brain injury, spinal cord injury, orthopedic conditions, amputations, neurological disorders, or multiple medical conditions. Following an acute medical episode for an injury, illness, or developmental disease, the member has demonstrated functional impairment in one or more of the following areas:

- **General mobility**: Difficulty with turning in bed, sitting up, balancing, transferring, moving about and maneuvering a wheelchair.
- **Self-care skills**: Problems with bathing, dressing, feeding self, swallowing, toileting, home management and money/math skills.
- **Perception**: Poor memory, lack of insight into limitations, poor concentration, disorientation, difficulty with thinking skills and making decisions, impaired safety awareness, difficulty perceiving the environment and impaired judgment. (This alone does not constitute appropriateness for acute inpatient)
- **Communication**: Inability to speak or understand speaking, difficulties with reading and writing.
- **Psychosocial functioning**: Inability to initiate or interact with others in a manner which is acceptable, AND
2. **The Member Is Medically Stable.**

The member must be capable of independent respiration and have no serious acute medical problems, such as uncontrolled seizures, uncontrolled infections, etc. Members are medically "stable," such that their medical conditions allow participation in a full acute rehabilitation program. Medical problems have been evaluated and determined not to interfere with member's potential to achieve rehabilitation goals. **AND**

3. **There is an expectation for significant practical involvement in a reasonable period of time.**

There is a reasonable expectation that:
1. The member will improve in a reasonable and generally predictable period of time **and**
2. The acute inpatient rehabilitation care will result in increased function, **and**
3. Functional I measurable goals are identified within 24 hours of admission and updated weekly hereafter, **and**
4. A satisfactory discharge plan to home will be achieved.

The member's mental and physical condition **prior to the illness or injury** indicates there is significant potential for improvement. It is not necessary that there be an expectation of complete independence in the activities of daily living, but there must be a reasonable expectation of improvement that is of practical value to the member, measured against his condition at the start of the rehabilitation program. For example, a multiple sclerosis member's condition may have deteriorated as a result of a secondary illness. To be restored to a level of function before the secondary illness, the member may require an intensive inpatient hospital rehabilitation program. While such a program does not restore the level of function before multiple sclerosis developed, a return to pre-secondary illness level is considered to be a "significant practical improvement" in the condition.

Since rehabilitation is essentially a learning process, the patient must have no lasting or major treatment impediment to learning, such as dementia or psychosis. However, a temporary impediment, such as acute head trauma, confusion or receptive aphasia that can be expected to improve, does not preclude admission. **AND**

4. **The member requires multidisciplinary comprehensive rehabilitation services as part of team program that cannot be achieved at a less intensive level of care.**

The member's deficits are such that he/she requires treatment by a multidisciplinary team in an acute inpatient rehabilitation setting, **AND** the intensity of service required can not be provided in a less intensive facility such as an SNF or on an outpatient basis. Acute inpatient rehabilitation programs must provide services not available in outpatient or skilled nursing facilities, including a multidisciplinary team approach. The patient must require 24-hour-a-day, skilled rehabilitation nursing care and physician services.

**Multidisciplinary Team Approach**
- A multidisciplinary team usually includes a physician, rehabilitation nurse, social worker and/or psychologist, and those therapists involved in the member's care.
- The member requires, actively participates in, and receives multidisciplinary team care, defined as at least two therapies (i.e., speech, occupational, physical, and/or respiratory therapies) provided on a daily basis (at least three to five hours per day, six to seven days per week).
- There must be documentation of multiple disciplinary team conferences to verify team coordination and patient progress based on objective benchmarks.

**Intensive Level of Care**
- The member must need more intensive rehabilitation services than those that can be provided by a skilled nursing facility or in an outpatient setting.
- The member's condition requires close medical supervision by a physician with specialized training or experience in rehabilitation and with 24-hour availability. This need should be verifiable by entries in the member's medical record that reflect frequent, direct, and medically necessary physician involvement in the member's care; i.e., at least every two to
three days during the member's stay.

This degree of physician involvement, which is greater than is normally rendered to a member in a SNF, is an indicator of a member's need for services generally available only in an acute inpatient setting. A SNF member's care usually requires only the general supervision of a physician, rather than the close supervision which hospital members need.

- The member also requires the 24-hour availability of a registered nurse with specialized training or experience in rehabilitation. This degree of availability represents a higher level of care than is normally found in an SNF. While an SNF member may require nursing care, specialized rehabilitation nursing is generally not as readily available in such a facility.
- The member must need therapeutic services in both quantity and diversity over and above those which a competent skilled nursing facility could provide, such as physical therapy, occupational therapy, speech therapy, psychology, cognitive remediation, dysphagia training and bladder/bowel training programs.
- A leave of absence (LOA) is a routine part of the inpatient rehabilitation program and is commonly utilized toward the end of the inpatient rehabilitation stay. Medical necessity must be questioned when requests for LOAs occur more than once during the inpatient stay or are for periods longer than six to eight hours in duration.
- Leave of absence is **NOT** allowed overnight. AND

5. **The member has sufficient cognitive and physical capacity to participate in a comprehensive inpatient rehabilitation program.**

The member is sufficiently mentally alert and responsive to verbal or visual stimuli and is able to follow simple commands, as evidenced by a **Rancho level V or higher.** (Refer to the Rancho Los Amigos Scale of Cognitive Functioning on page 13-21);

The member is able to tolerate and actively participate in a minimum of three to five hours of intensive therapy six to seven days per week. The member should be physically and mentally able to participate at least three to five hours a day in physical therapy, and/or occupational therapy in addition to other required therapies such as speech therapy, social services, psychological services, therapeutic recreation, vocational services and prosthetic/orthotic training.

While most members requiring an inpatient stay for rehabilitation need and receive at least three hours a day of physical and/or occupational therapy, there can be exceptions because individual member's needs vary. In some instances, members who require inpatient hospital rehabilitation services may need, on a priority basis, other skilled rehabilitative modalities such as speech-language pathology services, or prosthetic-orthotic services and their stage of recovery makes the concurrent receipt of intensive physical therapy or occupational therapy services inappropriate. In such cases, the three to five-hour a day requirement can be met by a combination of these other therapeutic services instead of or in addition to physical therapy and/or occupational therapy.

**Examples of Inpatient Rehab Disciplines and Services Provided as Part of a Multidisciplinary Team Program**

**Skilled Rehabilitation Nursing:**
- Bowel/bladder management.
- Medication management
- Member/family/caregiver training.
- 24-hour reinforcement of therapy goals/objectives.
- Ongoing assessment of patient status.

**Physical Therapy:**
- Treatment of limited mobility; e.g., inability to transfer, impaired coordination/truncal balance, functional ambulation less than 100 feet, passive and active range of motion of lower extremities.
- Instruction in use of DME.
Fitting of prosthetic and/or orthotic device(s).
Member/family/caregiver training.

**Occupational Therapy**
- ADL training; e.g., toileting, grooming, dressing, feeding.
- Perceptual motor training (spatial orientation, depth or distance perception) directly impacting ability to initiate and/or maintain freedom of movement in a safe environment.
- Member/family/caregiver training.
- Safety skills and/or problem-solving techniques; e.g., emergency procedures and injury prevention.
- Splinting of upper body extremities.

**Speech Therapy**
- Treatment of communication disorders (expressive and/or receptive dysphasia or aphasia) resulting in less than basic communication levels.
- Treatment of swallowing dysfunction (dysphagia).
- Teaching simple, problem-solving techniques and/or safety skills.
- Member/family/caregiver training.

**Social Services Medical Social Worker (MSW)**
- Integrates the member's and the family's social needs into the plan of care.
- Coordinates discharge planning activities.
- Makes community referrals and consults with other agency personnel.

**Neuropsychological Services**
- PhD. Prepared disciplines.
- Cognitive screening and neuropsychological testing.

**Physiatry:**
- Physician rehabilitation specialist.
- Daily medical supervision of the member's rehabilitation treatment plan.

---

**Refer to Physician Consultant:**

1. If the member has met optimal potential for recovery, and/or is no longer making functional progress towards goal of discharge, the request for extension of LOS should be referred for physician review.
2. **ALL** requests for direct admission from home must be referred for physician review.
3. For inpatient rehab stays past 3 weeks.
4. When sufficient progress is demonstrated such that the member can receive appropriate care in a less acute setting (i.e. ambulating greater than 100 feet, able to transfer SBA or CGA), or the member has attained functional physical improvement and can be treated in a lesser level of care, still may require 24 hour supervision.
5. Members unable to tolerate/actively participate at least three hours of intensive therapies per day, six to seven days a week.
6. Overnight and 24-hour passes are NOT approved. Passes may only be allowed if required to evaluate the member's ability to function at home or in the community before discharge.
7. Has exceeded goal length of stay.

---

**Rancho Los Amigos Cognitive Scale:**

This widely accepted scale serves as a guidepost of cognitive levels from admission through discharge.

**Level I** - no response to stimuli. Appears to be in deep sleep. Member is completely unresponsive to any stimuli.
Level II - generalized response. Has delayed, inconsistent responses. Member reacts inconsistently and non-purposefully to stimuli in a non-specific manner. Responses are often the same regardless of stimulus present. Responses may be physiological changes, gross body movement, and/or vocalization and are likely to be delayed.

Level III - localized response. Inconsistent responses, but reacts in a more specific manner to stimulus. Might follow simple commands. Member reacts specifically but inconsistently to stimuli. Responses are directly related to the type of stimulus presented as in turning the head toward a sound. He may follow simple commands in an inconsistent manner, such as closing his eyes, squeezing, or extending extremity. He may show a vague awareness of self and body by responding to some persons (especially family, friends) but not to others.

Level IV - confused/agitated. Reacts to own inner confusion, fear, and disorientation. Excitable behavior may be abusive. Member is in a heightened state of activity with severely decreased ability to process information. Behavior is frequently bizarre and non-purposeful relative to his immediate environment. Verbalization is frequently incoherent and/or inappropriate to the environment. He may be euphoric or hostile. Thus, gross attention to environment is very short and selective attention is often nonexistent. He is unable to perform self-care without maximum assistance.

Level V - confused/inappropriate, non-agitated. Usually disoriented. Follows tasks for two to three minutes, but easily distracted by environment. Member appears alert and is able to respond to simple commands fairly consistently. However, with increased complexity of commands, responses are non-purposeful. He may show agitated behavior. He has gross attention to the environment, but is highly distractible and lacks ability to focus attention to a specific task. Verbalization is often inappropriate. His memory is severely impaired with confusion of past and present. Member lacks initiation of functional tasks and often shows inappropriate use of objects without external direction. He may be able to perform previously learned tasks when structured for him, but is unable to learn new information. He responds best to self, body, comfort, and often family members. The member can usually perform self-care activities with assistance. The member may wander.

Level VI - confused/appropriate. Follows simple directions consistently. Memory and attention increasing. Self care tasks performed without help. Member shows goal-directed behavior, but is dependent on external input for direction. Response to discomfort is appropriate. He follows simple tasks he has relearned (such as self-care). Responses may be incorrect due to memory problems, but they are appropriate to the situation. Past memories show more depth and detail than recent memory. He no longer wanders and is inconsistently oriented to time and place. Selective attention to tasks may be impaired, especially with the difficult tasks and in unstructured settings, but is now functional for common daily activities. He may show a vague recognition of some staff, has increased awareness of self, family and basic needs.

Level VII - automatic/appropriate. If physically able, can carry out routine activities. Appears normal. Needs supervision for safety. Member appears appropriate and oriented within hospital/home settings, goes through daily routine automatically, but frequently robot-like. Has shallow recall of what he has been doing. He shows increased awareness of self. He has superficial awareness of, but lacks insight into this condition. Has decreased judgment and problem-solving abilities. He shows carry-over for new learning, but at a decreased rate. He requires at least minimal supervision for safety purposes. He is independent in self-care activities.

Level VIII - purposeful/appropriate. May have decreased abilities relative to premorbid state. Member is alert and oriented, is able to recall and integrate past and recent events. He shows carry-over for new learning and needs no supervision once activities are learned. Within his physical capabilities, he is independent in home and community skills, including driving. Vocational rehabilitation is indicated. He may continue to show a decreased ability, relative to premorbid abilities, in abstract reasoning, tolerance for stress, judgment in emergencies or unusual circumstances. His social, emotional, and intellectual capacities may continue to be at a decreased level for him, but functional in society.
14. PRESCRIPTION DRUG PROGRAM

Table of Contents

Prescription Drug Programs .............................................................................................................2
   Anthem Prescription Management ............................................................................................2
   Prescription Drug Benefit Programs ..........................................................................................2
   3-Tier Managed Rx Programs ....................................................................................................2
      HMO (BlueCare Health Plan) 3-Tier Rx Drug Program ......................................................2
      PPO (Century Preferred) 3-Tier Rx Drug Program .............................................................3
   3-Tier Managed Rx Program Components .........................................................................3
   Medications subject to Prior Authorization, Step-Therapy, or Quantity Limits ....................4
   Generic/Brand/Mail Order Programs .........................................................................................4
      Generic Drug Substitution ...................................................................................................5
      Specialty Pharmacy Program – PrecisionRx Specialty Solutions ......................................5
   Prescription Birth Control Benefits ...................................................................................................5
   Supply Limits ....................................................................................................................................6
   Claim Processing – APM ..................................................................................................................6
   Drug Utilization Review Programs ..............................................................................................6
   Pharmacy and Therapeutics Committee ..........................................................................................7
Prescription Drug Programs

Anthem Blue Cross and Blue Shield offers an array of optional prescription drug programs to members. Prescription drugs must be obtained from a participating network pharmacy to be eligible for in-network coverage. Members of all Anthem programs, including Century Preferred, BlueCare Health Plan and traditional programs, have access to the following:

- A network of more than 95 percent of all retail pharmacies in Connecticut;
- A national pharmacy network including more than 50,000 pharmacies nationwide for members who live, work or travel outside of Connecticut; and,
- A voluntary mail order prescription service for members who require maintenance medications.

Anthem Prescription Management

Anthem Prescription Management (APM), as a pharmacy benefits management company, manages the pharmacy networks and oversees pharmacy programs for Anthem Blue Cross and Blue Shield. If you have questions regarding prescription drug programs, please contact your provider relations representative. A link to the APM Web site can be found on anthem.com.

Prescription Drug Benefit Programs

Anthem offers a variety of copay and deductible prescription drug programs. Prescription drug coverage, when applicable, is indicated on the member’s ID card. To obtain a prescription, members simply have their scripts filled at a participating pharmacy. They are required to pay their applicable copay or cost-sharing amount at the time of purchase.

3-Tier Managed Rx Programs

Anthem also offers 3-Tier Managed Rx programs for our HMO and PPO members. Members with these programs will have “3-Tier” with applicable copays indicated on their ID card.

HMO (BlueCare Health Plan) 3-Tier Rx Drug Program

Examples of copays for the BlueCare Health Plan 3-Tier Rx Drug Program are:

<table>
<thead>
<tr>
<th>Option</th>
<th>Tier-1 Generic Drugs</th>
<th>Tier-2 Listed Brand-Name Drugs (Formulary Brands)</th>
<th>Tier-3 Non-Listed Brand-Name Drugs (Non-Formulary Brands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$5</td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>Option 2</td>
<td>$10</td>
<td>$20</td>
<td>$30</td>
</tr>
</tbody>
</table>

- There is a 30-day maximum for drugs purchased through a retail pharmacy, and a 90-day supply maximum through mail order.
- The following standard annual maximums are available with each cost share option: $500, $800, $2,000 and unlimited.
PPO (Century Preferred) 3-Tier Rx Drug Program

Examples of copays for the Century Preferred 3-Tier Rx Drug Program are:

<table>
<thead>
<tr>
<th>Option</th>
<th>Tier-1 Generic Drugs</th>
<th>Tier-2 Listed Brand-Name Drugs (Formulary Brands)</th>
<th>Tier-3 Non-Listed Brand-Name Drugs (Non-Formulary Brands)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Option 1</td>
<td>$5</td>
<td>$15</td>
<td>$25</td>
</tr>
<tr>
<td>Option 2</td>
<td>$10</td>
<td>$20</td>
<td>$30</td>
</tr>
<tr>
<td>Option 3</td>
<td>$10</td>
<td>$25</td>
<td>$40</td>
</tr>
</tbody>
</table>

- There is a 30-day maximum supply for drugs purchased at a retail pharmacy, and a 90-day maximum for drugs purchased through the mail order program.
- Members are responsible for two copays when purchasing a 31-90 day supply of maintenance medication through the mail order program.
- The following standard annual maximums are available with each cost share option: $500, $800, $2,000 and unlimited.

3-Tier Managed Rx Program Components

Prescription Drug List
The program incorporates a drug list and only those drugs listed are eligible for coverage under Tier 1 or Tier 2.

Please refer to the Anthem Drug List (Formulary) when prescribing a prescription medication to members of the 3-Tier Managed Rx Drug Program. These medications have been reviewed for safety and effectiveness by the Anthem National Pharmacy and Therapeutics Committee (see page 14-7).

- Members will still be able to obtain medications that are not listed on the formulary, but they will be responsible for a higher copay (and sometimes other out-of-pocket costs) than if they choose listed medications.

The Anthem drug list can be found on the Anthem Web site at anthem.com. Updates may be obtained by calling (887) 4MULARY (468-5279).

Prior Authorization (PA)

Certain medications require prior authorization criteria to be met prior to dispensing as a condition of coverage. Approval of the prior authorization is contingent upon the patient meeting the criteria established by the Anthem Pharmacy and Therapeutics Committee.

- For prior authorization, call the Prior Authorization Center at (800) 338-6180, or fax a completed PA request to (800) 601-4829.
- Prior authorizations are good for a maximum of one year.

The PA process is outlined on the Prior Authorization Request Form. If you do not have a copy of the prior authorization form, one can be found on our Web site, anthem.com, (on the Provider page for Connecticut, click on “Download Commonly Requested Forms”, or you can contact provider relations.
Generic Drug Substitution

- The 3-Tier Managed Rx Drug Program requires that prescriptions be filled with a generic whenever available. Generic drugs have the lowest member copay under this program.
- If a brand-name drug is dispensed when a generic is available, the member pays the applicable copay, plus the difference in cost between the brand and generic drug. This applies regardless of whether “dispense as written” or “no substitution” is indicated, unless the provider or pharmacist obtains prior authorization.
- A brand-name drug exception may be requested through prior authorization when the member has a documented allergic/adverse reaction or documented therapeutic failure.
- If prior authorization is obtained, the member will pay only the applicable copay.

Prescription Drug Quantity Limits

Certain covered drugs will have per-month quantity limits.

- Certain covered drugs have per-month quantity limits to help promote appropriate use and reduce the potential dangers of overuse.
- A provider may request an additional quantity, if clinically necessary, through prior authorization.

Medications subject to Prior Authorization, Step-Therapy, or Quantity Limits

A list of Prior Authorization, Quantity Limits and Step Therapy requirements, as defined below, is available on the Connecticut Provider page of our anthem.com Web site. These requirements are recommended by Anthem’s National Pharmacy and Therapeutics Committee under Anthem Prescription Management’s Clinical Connections Program, and have been approved to help promote access to safe, appropriate and effective drug benefits.

- Prior Authorization: required before the member can receive benefits to cover the medication
- Quantity Limit: Affects the monthly quantity of specified medication
- Step Therapy: Requires that another type of medication be used before the member will receive benefits for another medication.

Generic/Brand/Mail Order Programs

Common generic/brand/mail order drug programs include the following cost share options:

- $2 Generic/$7 Brand/$0 Mail Order
- $5 Generic/$10 Brand/$3 Mail Order
- $10 Generic/$15 Brand/$8 Mail Order

- $100 Individual/$200 Family Deductible
  - Covered at 80 percent for generic drugs
  - Covered at 60 percent for brand name drugs
  - The following standard annual maximums are available with each cost share option: $500, $800, $2,000 and unlimited.

- Oral contraceptive and sexual dysfunction coverage are optional (separately). The member should be aware if their prescription drug program includes either of these components.
Generic Drug Substitution

The majority of Generic/Brand/Mail Order prescription drug programs include a generic drug substitution program, which helps to maximize member benefits and control health care costs. Members are encouraged to use generic equivalent prescription drugs at a considerable savings compared to their brand name counterparts. By doing so, they save by paying a lower copay for prescription drugs and they maximize their prescription drug benefits.

However, if a brand drug is warranted for a member of a Generic/Brand/Mail Order program, “dispense as written” can be indicated on the script. Otherwise, the pharmacist will fill the prescription with a generic drug at the lower cost to the member.

Specialty Pharmacy Program – PrecisionRx Specialty Solutions

For the past few years the Anthem Rx Direct Specialty pharmacy program, owned and operated by Anthem Prescription Management, has provided direct delivery of specified biopharmaceutical drugs to participating physicians and providers of our commercial plans and programs as well as the BlueCare Family Plan. The specialty pharmacy program, now under the name PrecisionRX Specialty Solutions features:

- Dedicated Patient Care Coordinators who serve as your patient’s personal contact. The Patient Care Coordinator will call the patient when our system indicates that it’s time to refill his or her medication to help ensure timely delivery of the next shipment. They will also answer patients’ questions about benefits, or direct them, if desired, to one of our PrecisionRx Specialty Solutions team nurses or pharmacists if they have questions regarding their medication or condition.

- A clinical care management program led by a team of specialized nurses and pharmacists who understand your patient’s disease state is available to provide assistance. The specialty pharmacy care team is available to answer questions or to coordinate with your office as needed to help achieve favorable outcomes for your patient.

Refills Made Easy

Our PrecisionRx Specialty Solutions Patient Care Coordinators will call your patients to further explain the enhanced specialty pharmacy program and to schedule a convenient delivery date for their next shipment. The orders will be delivered in a nondescript package directly to the patient’s home, to your office, or other specified location along with the necessary administration supplies (i.e. needles, syringes, etc.), often at no additional cost.

To order specialty medications through PrecisionRx Specialty Solutions for new specialty customers, a Prescription Enrollment Form and a list of specialty medications provided under this program are available on anthem.com at __________, or may be obtained by calling (800) 870-6419.

If you or your patients have any questions about PrecisionRx Specialty Solutions, they can be reached at (800) 870-6419, Monday through Friday, from 8 a.m. to 9 p.m., Eastern Time.

Prescription Birth Control Benefits

Under State law, health insurers are required to provide coverage for prescription birth control drugs as part of any outpatient insured prescription drug program.

In compliance with this law, all commercial Anthem insurance plans with outpatient prescription drug coverage will include coverage for prescription birth control, which includes: oral contraceptives, contraceptive patches, and Depo-Provera®.

Please note: For self-insured groups, such coverage is optional. In addition, fully insured, bona fide religious organizations have the option of excluding prescription birth control.
Supply Limits

HMO (BlueCare Health Plan)
For the BlueCare Health Plan programs the maximum supply of a prescription drug for which benefits will be provided under any one prescription follows:

- A 30-day maximum supply for drugs purchased through a retail pharmacy.
- A 31-90 day maximum supply through mail order.

PPO (Century Preferred)
For the Century Preferred plans and programs indicated, the maximum supply of a prescription drug for which benefits will be provided under any one prescription is:

- A 30-day maximum supply for drugs purchased at a retail pharmacy.
- A 31-90-day maximum for drugs purchased through the mail order program.

Please Note: Certain high cost drugs may be covered through our case management program. To inquire about this program, please contact our Utilization Management Department.

Claim Processing – APM

All pharmacy claims for Anthem Blue Cross and Blue Shield plans and programs are processed by Anthem Prescription Management (APM). APM also handles all pharmacy claim inquiries and prior authorization inquiries from participating physicians and pharmacies.

Telephone and fax numbers for pharmacy inquiries and prior authorizations:

Phone (800) 338-6180
Fax: (800) 601-4829

Pharmacy claims mailing address:

Anthem Prescription Management, LLC.
8990 Duke Drive
Mason, OH 45040

Drug Utilization Review Programs

Prescription Drug Use Evaluation is performed to monitor formulary compliance and prescribing guidelines. Drug Use Evaluation helps to assure appropriate prescribing patterns and promotes cost effective, quality care. The program is three-fold:

1. Clinical Frontline – an educational program to assist physicians in prescribing before the prescription is written. This is accomplished through the formulary and pharmacy utilization system edits.
2. Clinical Connection – performed at the time a prescription is dispensed, making use of an on-line database. This enables the pharmacist to protect the patient from potential drug-to-drug or drug-to-disease interactions or harmful therapeutic duplications. The pharmacist will be alerted to any potentially serious clinical problems associated with the prescriptions and will intervene if a problem is suspected.
3. Clinical Outreach – performed after the prescription has been dispensed. Retrospective review examines the prescribing patterns of physicians in comparison to his or her peers. Through retrospective review, educational needs for physicians and members can be identified and addressed to promote optimal use of drugs.

Issues identified through Clinical Connection and Outreach will be communicated to physicians via correspondence from Anthem Prescription Management. If you have any questions or comments regarding the drug utilization programs, please contact the Provider Call Center.
Pharmacy and Therapeutics Committee

A Pharmacy and Therapeutics (P&T) Committee is an important component of the clinical pharmacy program. The committee is comprised of practicing physicians and retail pharmacists, including network providers, and representatives from Anthem. The P&T Committee:

- Oversees the clinical pharmacy activities, including drug utilization management;
- Maintains and revises the prescription drug formulary as necessary, based upon objective evaluation of the therapeutic merits, safety and costs;
- Amends the formulary based on physician requests for evaluation of drugs; and,
- Serves in an advisory capacity in matters pertaining to the use of drugs, as well as recommending programs and procedures that promote cost-effective drug therapy.
15. COORDINATION OF BENEFITS (COB)

Table of Contents

The Claim Recovery Department and the various customer action teams are responsible for administering benefits when the member’s treatment may be covered by another insurance.

Key Telephone Numbers......................................................................................................................................2

General COB Guidelines.....................................................................................................................................2
  The Birthday Rule ............................................................................................................................................3
  Separated or Divorced Parents.......................................................................................................................3
  Active Employees...............................................................................................................................................3
  OBRA.........................................................................................................................................................3

Claim Submission..............................................................................................................................................3
  Billing............................................................................................................................................................3
  Duplicate Coverage ......................................................................................................................................4

Compensation ...................................................................................................................................................4

Third Party Payors...........................................................................................................................................4
  Worker’s Compensation .................................................................................................................................4
  No-Fault Automobile Insurance ..................................................................................................................4
  Subrogation ..................................................................................................................................................5
### Key Telephone Numbers

**Participating physicians and health care providers:**

Claim Recovery or Right-to-Recovery Claims  
(Provider Call Center)  
(800) 922-3242 (toll free in Conn.)  
or (203) 239-3884 (local North Haven)

**Non-participating physicians and health care providers:**

The Member’s Customer Business Unit (CBU)  
(800) 922-1742 (toll free in Conn.)  
or (203) 239-4911 (local North Haven)

### General COB Guidelines

Coordination of Benefits (COB) is the legal order of benefits determination guideline that Anthem Blue Cross and Blue Shield and other insurers use to help ensure that members access their benefits appropriately but without duplication when a person is covered by more than one health benefit plan. However, when duplication does exist, both health benefit plans can be coordinated to provide maximum coverage.

Anthem follows state and/or federal guidelines in determining a plan’s primary or secondary responsibilities:

- The plan that covers a person as the **subscriber/employee** is the **primary plan**.
- The plan that covers a person as a **dependent** is the **secondary plan**.
- The birthday rule applies for covered child dependents when two plans cover the same child as a dependent of different persons (i.e. parents).

The following definitions may be helpful when discussing COB:

- **Group insurance**: A plan that is provided through an employer.
- **Direct-pay insurance**: A plan that the subscriber does not obtain through a group and is billed directly to the subscriber at home.
- **Subscriber**: The person who has entered into the health insurance contract, which may provide benefits for his/her family members.

Anthem members should notify their plan about any additional coverage they have. Because this notification is not always timely, physicians and health care providers are advised to request updated information at the time of service.

**When Anthem is the secondary plan:**

- The member or billing physician/health care provider must submit to Anthem an explanation of benefits from the primary insurer in order to receive payment for any remaining balance.
- We will consider charges up to the negotiated allowed amount with the primary carrier.
- We will provide compensation for member cost sharing responsibilities for eligible covered services in accordance with the provisions of the members coverage document.
The Birthday Rule

This rule applies when non-separated and non-divorced parents have different health plans, both of which cover children as dependents. The plan benefits of the parent whose birthday falls earlier in the calendar year (month and day) are determined first. If both parents have the same birthday, the plan which has been in effect longer is considered primary.

Separated or Divorced Parents

If two or more plans cover dependent children of separated or divorced parents who do not have joint custody of their children, the children’s primary benefits are determined in this order (unless specified otherwise in a court decree):

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent (if the parent has remarried).
- The plan of the parent without custody.
- In cases of joint custody, the birthday rule applies.

Active Employees

When an active employee has a plan with his/her present employer and is still covered by a former employer’s plan as a retiree or a laid-off employee, the plan covering that person as an active employee is primary.

OBRA

For End-Stage Renal Disease (ESRD) patients, Anthem coverage is primary for the first 18 months of dialysis. This coverage continues for the first 18 months regardless of whether the member reaches the age of Medicare eligibility. Medicare becomes primary on the first day of the nineteenth month.

Claim Submission

Billing

Always submit charges to the primary plan first.

- **When an Anthem plan is primary**, collect the copay. This copay is deducted from your claims payment.

- **When an Anthem plan is secondary**, do not collect a copay unless the primary plan does not cover the service, or if the member is satisfying a deductible for the primary plan.

When a claim is paid or rejected by the primary plan, an explanation of benefits (EOB) should accompany the check or denial notice. Bill charges for non-covered or unpaid services to the secondary plan, and attach the explanation of benefits.

When Anthem is the secondary carrier, we will consider charges up to the negotiated allowed amount with the primary carrier. As the secondary carrier, Anthem will provide compensation for member cost sharing responsibilities for eligible covered services in accordance with the provisions of the member’s coverage document.

**Timely Filing:**

- Claims submitted after the filing limit will not be eligible for processing.

- COB Claims: When benefits are coordinated (COB), the timely filing limit is **90 days** from the date of payment by the primary payor.
Duplicate Coverage

When a family is covered by two Anthem Blue plans or programs, the order of benefit determination explained under “General COB Guidelines” on page 15-2 applies.

• Submit one claim under the membership identification number of the patient.
• Indicate on lines 9a-d of the red CMS-1500 claim form the secondary information.
• The appropriate Anthem program will make payments under both membership identification numbers as applicable.

Compensation

When an Anthem plan is primary:

• Compensation will be in accordance with the provider's agreement.
• Compensation is subject to copays and risk withhold (when applicable).

When an Anthem plan is secondary:

• Compensation will be in accordance with the provider's agreement.
• Compensation is subject to risk-withhold (when applicable).
• No copays apply unless the primary insurer pays no portion of the claim.

Third Party Payors

Worker’s Compensation

• If the medical services are rendered for a work-related injury, the Worker’s Compensation carrier is liable.
• Submit the claim to the compensation carrier through the member’s employer.
• If Worker’s Compensation is denied, you should receive a denial notice.
• Submit the denial notice with the CMS-1500 claim form to Anthem for processing.
• When a claim is denied by a Worker’s Compensation carrier because the member did not follow the carrier's managed care protocol, the services are not eligible for coverage by Anthem.
• An Anthem member must abide by all applicable terms and conditions of coverage, including referrals, or the claim will be denied by Anthem, even when worker’s compensation is denied.

No-Fault Automobile Insurance

The following rules apply to No-Fault automobile insurance* and coordination of benefits:

• If the member does not have No-Fault or “Med Pay” coverage, Anthem will be responsible for coverage, subject to the applicable terms and conditions of the member’s benefits.
• If the member has No-Fault or “Med Pay” automobile coverage, that carrier may be liable for basic reparations related to an auto accident. Anthem reserves the right to coordinate benefits with any No-Fault or “Med Pay” policy. If the Anthem coverage is to be used to cover additional medical services, the company’s policies must be followed.
• When incurred expenses related to an auto accident exceed the No-Fault or “Med Pay” coverage, submit the Explanation of Benefits from the No-Fault or “Med Pay” carrier with the HCFA-1500 claim form to Anthem for processing.
  * Each state has its own No-Fault insurance laws.

• Worker’s compensation, or No-Fault and “Med Pay” automobile claims may not be resolved within the timely filing period because of questionable circumstances. Please advise Anthem of all worker’s compensation or No-Fault/“Med Pay” automobile cases. To ensure consideration, you must submit the claim to Anthem within the filing period, for denial. This will enable Anthem to re-open and process the claim, after the timely filing limit, once the other carriers have paid their portion, if applicable.

**Subrogation**

• To the extent permissible by law, Anthem shall have a right of compensation for benefits provided in connection with injuries resulting from third party negligence where the member exercises his or her rights of recovery against a third party or other insurance.

• Anthem will process claims routinely.

• Anthem staff will contact the member directly and, if necessary, the member’s attorney, to recover payment.

• The timely filing period for claims involving subrogation is two years.

• Participating physicians and health care providers cannot hold Anthem members financially responsible for an amount that exceeds the contracted compensation with Anthem.
### 16. CLAIM FILING

#### Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claim Submission Addresses &amp; Phone Numbers</td>
<td>2</td>
</tr>
<tr>
<td>BlueCard Out of Area</td>
<td>2</td>
</tr>
<tr>
<td>BlueCare Health Plan</td>
<td>2</td>
</tr>
<tr>
<td>Century 90</td>
<td>2</td>
</tr>
<tr>
<td>Century Preferred</td>
<td>2</td>
</tr>
<tr>
<td>Commercial Plans and Programs (HMO and PPO)</td>
<td>2</td>
</tr>
<tr>
<td>Federal Employee Program – Standard Option and Basic Option</td>
<td>3</td>
</tr>
<tr>
<td>National Accounts (PPO USA)</td>
<td>3</td>
</tr>
<tr>
<td>New England Health Plans</td>
<td>3</td>
</tr>
<tr>
<td>(HMO Blue New England and BlueChoice New England)</td>
<td>3</td>
</tr>
<tr>
<td>State of Connecticut</td>
<td>3</td>
</tr>
<tr>
<td>Taft-Hartley (Teamsters)</td>
<td>3</td>
</tr>
<tr>
<td>Timely Filing Limits</td>
<td>3</td>
</tr>
<tr>
<td>Compensation for Services Provided by a Vendor</td>
<td>4</td>
</tr>
<tr>
<td>Clean Claim</td>
<td>4</td>
</tr>
<tr>
<td>Tips on Coding Claims</td>
<td>4</td>
</tr>
<tr>
<td>Claim Submission for Non-MD and Allied Providers</td>
<td>5</td>
</tr>
<tr>
<td>Multiple Surgery Compensation</td>
<td>5</td>
</tr>
<tr>
<td>Our Policy on Physician/Provider Self/Family Treatment</td>
<td>5</td>
</tr>
<tr>
<td>Electronic Claim Submission</td>
<td>5</td>
</tr>
<tr>
<td>Anthem Online Provider Services (AOPS)</td>
<td>6</td>
</tr>
<tr>
<td>Red CMS(HCFA)-1500 Claim Form Submission</td>
<td>6</td>
</tr>
<tr>
<td>Optical Character Recognition Scanning</td>
<td>7</td>
</tr>
<tr>
<td>Sample CMS-1500 Claim Form</td>
<td>8</td>
</tr>
<tr>
<td>Completing the CMS-1500 Claim Form</td>
<td>9</td>
</tr>
<tr>
<td>Covering Situations for BlueCare Health Plan Programs</td>
<td>12</td>
</tr>
<tr>
<td>Non-participating Covering Physicians</td>
<td>12</td>
</tr>
<tr>
<td>Locum Tenens</td>
<td>12</td>
</tr>
<tr>
<td>Provider Remittances</td>
<td>13</td>
</tr>
<tr>
<td>Remittances</td>
<td>14</td>
</tr>
<tr>
<td>Remittances for Paper and Electronic Claims</td>
<td>14</td>
</tr>
<tr>
<td>Explanation of Remittance Voucher</td>
<td>14</td>
</tr>
<tr>
<td>Sample Provider Remittance</td>
<td>15</td>
</tr>
<tr>
<td>BlueCare Health Plan Provider Patient Listing/Active Membership Report</td>
<td>16</td>
</tr>
<tr>
<td>Overpayment and Refund Procedures</td>
<td>16</td>
</tr>
<tr>
<td>Ensuring Proper Financial Reporting</td>
<td>17</td>
</tr>
<tr>
<td>Individual Practices</td>
<td>17</td>
</tr>
<tr>
<td>Group Practices</td>
<td>17</td>
</tr>
</tbody>
</table>
Claim Submission Addresses & Phone Numbers

**BlueCard Out of Area**

- **BlueCard Traditional, HMO or PPO:**
  - **Claim Inquiries:** (800) 895-9915 (in Conn.), or (203) 499-6238
  - **Medical/Surgical and Behavioral Health Claims to:**
    - Anthem Blue Cross and Blue Shield
    - P.O. Box 533
    - North Haven, CT 06473-0533

- **BlueCard POS**
  - **Claim Inquiries:** (800) 327-9232 (nationwide), or (800) 233-6183 (in Conn.)
  - **Medical/Surgical Claims to:**
    - Anthem Blue Cross and Blue Shield
    - P.O. Box 726
    - North Haven, CT 06473-0726
  - **Behavioral Health Claims:**
    - Call Home Plan number on back of member ID card.

**BlueCare Health Plan**

(See Commercial Plans and Programs below)

**Century 90**

(See Commercial Plans and Programs below)

**Century Preferred**

(See Commercial Plans and Programs below)

**Commercial Plans and Programs (HMO and PPO)**

For **BlueCare Health Plan** (not **BlueCare Family Plan**), **Century Preferred** (including **Century Preferred Comp & PCA**, **Century Preferred Direct** and **Century Preferred HSA**), State of Connecticut:

- **Claim Inquiries, Medical/Surgical:** (800) 922-3242 (in Conn.) or (203) 239-3884 (local North Haven)

- **Claim Inquiries, Behavioral Health:** (800) 934-0331

- **Medical/Surgical and Behavioral Health Claims:**
  - Anthem Blue Cross and Blue Shield
  - P.O. Box 533
  - North Haven, CT 06473-0533

For **Century 90** and Indemnity Programs:

- **All Claim Inquiries:** (800) 922-3242 (in Conn.) or (203) 239-3884 (local North Haven)

- **Medical/Surgical and Behavioral Health Claims**
  - Anthem Blue Cross and Blue Shield
  - P.O. Box 533
  - North Haven, CT 06473-0533
Federal Employee Program – Standard Option and Basic Option

All Claim Inquiries: (800) 438-5356

Medical/Surgical and Behavioral Health Claims to:
Anthem Blue Cross and Blue Shield
P.O. Box 37790
Louisville, KY 40233-7790

National Accounts (PPO USA)

All Claim/Membership Inquiries: (800) 224-5105

Claims: Address varies according to member Home plan. Check member ID card or call Home Plan for claim information.

New England Health Plans

(HMO Blue New England and BlueChoice New England)

Claim Inquiries: (800) 922-3242 (in Conn.), or (203) 239-3884 (local North Haven)

Claim Address:
Medical/Surgical and Behavioral Health Claims to
Anthem Blue Cross and Blue Shield
P.O. Box 533
North Haven, CT 06473-0533

State of Connecticut

(State BlueCare and State Preferred, see Commercial Plans and Programs above.)

Taft-Hartley (Teamsters)

Benefits and plan requirements vary. Check member ID card, or contact the dedicated Taft-Hartley Fund Service Unit at (888) 287-0032 with inquiries.

Timely Filing Limits

Claims should be submitted to Anthem consistently, accurately and within timely filing limits to ensure the quickest turnaround time for compensation. This section will assist you with the requirements and guidelines for submitting claims.

In order to receive timely, direct compensation from Anthem for services you render as a participating physician or health care provider, the following claims filing limits apply. Claims submitted after the filing limit will not be eligible for processing.

The timely filing deadline is 120 days from the date of service for the following health plans:

- BlueCare Health Plan (including State BlueCare and New England Health Plans)
- Century Preferred (including State Preferred)
- Century 90 (and its various riders)

FEP Claims: The timely filing deadline is December 31 of the calendar year following the date of service

Please note the following:

- Electronic claims: If you submit claims electronically, you should always check to see if your claims were received and accepted by checking your Claims Detail Report. See the Aug. 2003 issue of the Administrative Update for more information about the Claims Detail Report.
- Paper Claims: If you submit paper claims, but sure to run aging reports of outstanding claims at 30, 60 and 90 days to eliminate the possibility of late claims.
**COB Claims:**

- When benefits are coordinated, and Anthem is the secondary payor, the timely filing limit to submit the claim to Anthem Blue Cross and Blue Shield is 90 days from the date of the primary payor’s EOB.

- If you are billing another carrier such as auto insurance or worker’s compensation, and you know the member is also a member of an Anthem plan or program, be sure to bill Anthem at the same time as the other carrier so that we have a timely record of the services you have rendered.

**Please note the following:**

- **Electronic claims:** If you submit claims electronically, you should always check to see if your claims were received and accepted by checking your Level three Claims Detail Report.

- **Paper Claims:** If you submit paper claims, be sure to run aging reports of outstanding claims at 30, 60 and 90 days to eliminate the possibility of late claims.

### Compensation for Services Provided by a Vendor

If your practice enters into an agreement with and/or uses a vendor who is a non-participating provider with Anthem Blue Cross and Blue Shield for services such as heart monitoring, please note:

- Claims for those services performed on your behalf by a vendor must be submitted with your name and 13-digit Anthem participating provider number in the appropriate areas of the CMS-1500 or electronic claim form.

- Payment for these services will be made directly to your office as a participating provider, and will appear on your Anthem remittance statement.

- Your practice should reimburse the vendor directly.

### Clean Claim

In order to process a claim, Anthem must determine that the claim is a clean claim according to the following guidelines:

- **When Anthem is the primary plan,** a clean claim is one which is complete, accurate and submitted in accordance with the requirements described in this section, including but not limited to timely filing limits, appropriate format, complete information and supplemented by any additional information as required by Anthem.

- **When Anthem is the secondary plan,** a clean claim is one which meets all the requirements above and is submitted with an explanation of benefits from the primary insurer as described in the Coordination of Benefits section.

Determination of a clean claim shall be made by Anthem in its sole discretion, in accordance with any applicable laws.

### Claim Submission Tips

**Coding Claims**

According to the Health Care Financing Administration (CMS) guidelines, ICD-9-CM codes should always be included on claims at their highest level of specificity.

When coding claims, always be sure to use the complete service code provided, as follows:

- If the code has a **fifth digit** subclassification, the complete code should always be included.

- Include **four digit** codes only when fifth digit codes are not available within the coding category.

- Use **three digit** codes only when fourth and/or fifth digit codes are not available within the coding category.

Correct coding of claims will help with the adjudication process and prevent payment delays.
Include Your Full Charges on All Claims!
Please be sure to always include your full charges for the services rendered to all Anthem members and Blue Cross & Blue Shield members from other states, not the discounted amount that will be remitted to you by Anthem, in box 28 on the CMS-1500 claim form. Accurate charge data is very important to us, because the information allows us to monitor the actual cost of health care.

Claim Submission for Non-MD and Allied Providers

- Claims for all non-MD and allied providers participating with any of our commercial networks must be submitted under the unique 13-digit provider ID number assigned to the provider that actually rendered the service. This ID number, issued by Anthem, incorporates the provider’s license number.
- This applies to, but is not limited to Chiropractors, Physical Therapists, APRNs, Midwives and Physician Assistants, and encompasses those providers who are part of a multi-specialty practice. This also applies to non-MD and allied providers who are not participating.
- If a claim for these services is submitted under a physician’s name, and the service was not provided by that physician, the practice will be subject to audit.

Multiple Surgery Compensation

BlueCare Health Plan, Century Preferred and Comprehensive Plans and Products
If you provide more than one surgical procedure for a patient in the same day, approved consecutive procedures will be paid at different levels. The first highest allowance will be paid at 100 percent of the maximum allowable amount (MAA); the second highest will be paid at 50 percent of the MAA. If there is a third procedure, or if there are additional procedures that same day, they will be paid at 25 percent of the MAA.

Century 90 Plans
If you provide more than one surgical procedure for a patient in the same day, approved consecutive procedures will be paid at different levels. The first highest allowance will be paid at 100 percent of the maximum allowable amount (MAA); the second highest will be paid at 50 percent of the MAA. If there is a third procedure, or if there are additional procedures that same day, with a few exceptions, they will not be compensated separately.

Our Policy on Physician/Provider Self/Family Treatment

Important Reminder: Under Anthem policy, services rendered by a physician or other provider to him/herself, or for services rendered to his or her immediate family, including parents, spouses, children, grandchildren or any other immediate family member or relation are not eligible for coverage.

Electronic Claim Submission

By electronically submitting claims for Anthem members, you can:
- Rely on weekly claims remittances;
- Profit from quick, accurate claims processing that will increase your cash flow;
- Access members’ coverage and eligibility status data quickly and easily;
- Take advantage of electronically transmitted files and reduce the time-consuming process of posting payments to patient accounts; and,
- Shorten waiting periods between claims submission and remittance, and improve overall efficiency.
If you would like to inquire about how you can submit your claims electronically, contact:

The EDI Help Desk
(800) 334-8262

Information Required for Electronic Submission of Claims:
There is a list of services in Appendix D of this Manual which are eligible for compensation only if specific information on the services rendered is provided when the claim is filed. When filing electronically, the 80 character documentation text or the free form narrative must be entered. This information is to be filled in when submitting claims for any of the services identified on the list, which indicates the code, a description of the service and the information required.

Anthem Online Provider Services (AOPS)

Anthem.com ➔ select Providers ➔ select Connecticut ➔ click on Anthem Online Provider Services (AOPS Provider Home Page)

Anthem Online Provider Services (AOPS), is our secure Internet site specifically developed for our participating providers. It is available nearly 24/7 at no charge and offers a wealth of information, including coverage and claim status information.

Documents with detailed descriptions about the services available on AOPS, as well as the Quick Reference Guide, are available to current users by clicking on the NEWS link located at the top of the AOPS Provider Home Page.

We encourage you to share your opinions and comments by completing our online survey available on the AOPS Provider Home Page by clicking on Help Us Out. We appreciate your feedback, as it helps us enhance AOPS to meet your needs.

Not Yet Registered?
It’s simple! Participation requires completion of a signed User Agreement, which is available on the AOPS Provider Home Page by clicking on Sign Up Now, or you can contact the Provider Call Center at (800) 922-3242 or (203) 239-3884, and ask to speak with your Provider Representative.

Red CMS(HCFA)-1500 Claim Form Submission

Use of the red CMS-1500 claim form is required by Anthem, as this standardized form promotes accurate and timely claims processing. It also allows you to take full advantage of optical character recognition scanning, an electronic processing system that eliminates the manual keying of claim data, increasing the efficiency and timeliness of the claims payment process.

In accordance with Connecticut state law and Anthem administrative policies, all claims submitted manually by participating and/or preferred physicians and health care providers must be submitted using the red CMS-1500 claim form. (Claims for prescription drugs, home care, dental and out-of-state services are not affected by this requirement.)

Superbills and other forms will not be accepted in place of a red CMS-1500 or as a substitute for any of the information required on the CMS form. All red CMS-1500 forms must be completed according to the requirements outlined on the following pages in order to be processed.

A sample CMS-1500 claim form is on page 16-8 of this section.
Attaching a superbill to your completed red CMS-1500 claim form in place of a completed CMS-1500 form will result in rejection of the claim. A superbill attached to the form is acceptable only as a supplement to, and not a replacement for, information required on the CMS-1500, unless it provides information that is not already required on the form.

**Optical Character Recognition Scanning**

In an effort to make claims processing faster, more efficient and more accurate, Anthem utilizes optical character recognition scanning. This process allows properly completed, single-sheet, red CMS-1500 claim forms to be scanned in seconds.

Please refer to the guidelines listed below to take advantage of this technology and to help assure faster and more accurate claims processing and compensation for covered services:

- Submit only single-sheet, red CMS-1500 claim forms. (Black CMS-1500 forms, photocopies, carbons, and forms with superbills or other information attached cannot be scanned). Supporting documentation (such as operative reports) should continue to be submitted when required.

- Include only the requested information in the appropriate order and in the correct box on the CMS-1500 claim form. The following cannot be scanned and will result in a longer processing time:
  - Information that runs beyond the perimeter of the box,
  - Hand-written or stamped information, or
  - Information not in the correct order or in the appropriate box.

- List only the primary ICD-9 diagnostic code in Box 24e or the corresponding diagnosis cross-reference numbers “1, 2, 3, 4.” Be sure to use commas to separate multiple diagnosis cross-reference numbers. Do not use A, B, C, or D in place of the numbers.

- In Box 33 of the CMS-1500 claim form indicate the name, street address and Anthem 13-digit provider number of the individual physician or health care provider rendering the services. The provider number should be listed on the bottom line, where “PIN#” is indicated. Do not list telephone numbers in this box. A corporation title or name may appear in Box 33, along with the appropriate 13-digit provider number in the following cases only:
  - MRI centers
  - Laboratories
  - Rehabilitation centers
  - Ambulance companies
  - Durable medical equipment suppliers
  - Other special providers

- Indicate the full amount of all charges submitted. The equipment scans charge amounts by reading the number of digits listed and automatically places a decimal point just before the second-to-last digit on each charge line. Not listing the cents portion of your charge will cause your compensation to be calculated incorrectly.

- Type or computer-generate all information on the CMS-1500 claim form (do not use script fonts). The best fonts to use are those listed below:

  - Dual Gothic 12
  - Mini Gothic 15
  - Letter Gothic 10
  - Orator 10
  - Courier 10
  - Pica 10
  - Prestige Pica 10
  - Manifold 10
  - Letter Gothic 12
  - Prestige Elite 12
  - Courier 12
  - Letter Gothic Mini 15
  - Elite 12

- Typed or computer-generated information is a requirement for claims processing by the optical character recognition scanning system. Hand-written claim forms submitted for processing will not be scanned; therefore, there may be a delay in the processing of hand-written claims.

- Change printer ribbon frequently. Light print cannot be scanned, as it may make certain characters unrecognizable. (If you use a dot matrix printer, be sure to print your claim forms using letter-quality print.)
Sample CMS-1500 Claim Form

HEALTH INSURANCE CLAIM FORM

signature on file 04-15-97

= 250.0  65.00

Signature on file 04-15-97

 Anthem Blue Cross and Blue Shield Policies & Procedures Manual 16 - 8
2005 Rev.
Completing the CMS-1500 Claim Form

Please Note:

Information Required for Payment of Claims
There is a specific list of services which are eligible for compensation only if specific information on the services rendered is provided when the claim is filed. The list can be found in Appendix D of this Manual. The information should be attached to the CMS claim form. This information is to be provided when submitting claims for any of the services identified on the list, which indicates the code, a description of the service and the information required.

Box 1. Not a required field.* Check the box that corresponds to the program name for the member. The box for “OTHER” would be most appropriate for our members.

Box 1a. Print the member’s identification number. For BlueCare Health Plan members, the identification number is 10 digits. For Anthem and out-of-area Blue Cross and Blue Shield members, the identification numbers are 13 digits - the regular 10-digit identification number plus a three-digit alpha prefix.

Box 2. Print the patient’s full name - last name first, first name second, then middle initial.

Box 3. Print the patient’s birth date in an eight-digit format, and check the box that corresponds to the patient’s gender.

Box 4. Print the subscribing member’s full name - last name first, first name, then middle initial.

Box 5. Print the patient’s address.

Box 6. Check the box that corresponds to the patient’s relationship with the member.

Box 7. Print the subscribing member’s address.

Box 8. Not a required field.* Check the boxes that correspond to the patient’s marital and employment status.

Box 9. If the member is covered by another group health plan, the name of the other carrier should be indicated. If there is no other coverage, please indicate “none” or leave blank. (Do not indicate Anthem Major Medical.)

Box 9a. Print the identification number corresponding to the other coverage if known.

Box 9b. Print the date of birth and check the appropriate box for gender if known.

Box 9c. Print the employer name or school name.

Box 9d. Print the insurance plan name or program name.

Box 10. When applicable, check the box that corresponds to the nature of the injury - a. employment, b. auto accident or c. other accident.

Box 10d. Not a required field.* Reserved for local use.

Box 11. Print the member’s group policy or FECA number.

Box 11a. Print the member’s date of birth, using the complete 4-number year designation, and check the appropriate box for gender.

Box 11b. Print the member’s employer name or school name.

Box 11c. Print the member’s insurance plan name or program name.

Box 11d. Check the appropriate box; if the answer is yes, please complete boxes 9a - 9d.

* Completion of this box is not required for claims processing. The information included here on non-required fields is simply a guideline for completion should you choose to complete these sections.
**Boxes 12 and 13.** Complete these boxes to accept assignment of compensation. These boxes apply only to Anthem participating and/or preferred physicians or health care providers accepting assignment under the Comprehensive or Wraparound programs. The member’s signature is not required when the physician or health care provider rendering medical services is participating and/or preferred. To receive direct compensation for covered services rendered to Group Comprehensive or Wraparound members when submitting paper, pin-fed or electronically transmitted claims, the phrase “signature on file” must be placed in these boxes. The member’s actual signature must be obtained and kept in the physician/health care provider’s records.

**Box 14.** Print the date of the illness (first symptom, injury, pregnancy).

**Box 15.** If the patient has had the same or similar illness, print the date of onset.

**Box 16.** Not a required field (unless the patient has been disabled and is unable to return to work for any period of time).*

**Box 17.** Print the name of the referring or referred-to physician. (For BlueCare Health Plan members in programs requiring referral authorization by a PCP.)

**Box 17a.** Print the UPIN or referral authorization number of the referring or referred-to physician, if box 17 is completed. (For BlueCare Health Plan members in programs requiring referral authorization by a PCP.)

**Box 18.** Print the admission and discharge dates for services related to a hospitalization.

**Box 19.** Not a required field.* Reserved for local use.

**Box 20.** Check the appropriate box if an outside lab was used. **IMPORTANT (excluding commercial labs): If “Yes” is checked, claim should not be billed by this provider.** Payment for laboratory services is made only to the entity actually performing the test.

**Box 21.** Print diagnosis (ICD-9) codes which relate to box 24, line items 1 through 6. A maximum of 4 diagnosis codes can be indicated. A description of the ICD-9 codes is not necessary.

**Box 22.** Not a required field.* Not used.

**Box 23.** Not a required field.* Print the prior authorization number, if applicable.

**Box 24a.** To indicate date(s) of service, follow these guidelines:
- From and to dates can be used to indicate like services and/or treatments. Individual dates within the time frame must be provided within the body of the claim form.
- The date of service requires six positions, listed in the following order: month, day and year. Multiple services provided on the same date must be listed on the same claim form.

**Box 24b.** Print the appropriate place-of-service code.

**Box 24c.** Print the appropriate type-of-service code.

**Box 24d.** Print the appropriate CPT or HCPCS codes and modifiers, as applicable. Refer to the CPT or HCPCS coding manuals. If a description of service is necessary, please attach it to the red CMS-1500 claim form upon submission.

**Box 24e.** Print the appropriate diagnosis code, using ICD-9 diagnostic codes. You may also print 1, 2, 3 or 4, or any combination, to cross reference a code indicated in box 21. The numbers must be separated by a comma.

**Box 24f.** Print your actual charge for the services being rendered. Do not print the fee schedule amounts.

**Box 24g.** Print the number of days or units for which the service was provided.

*Completion of this box is not required for claims processing. The information included here on non-required fields is simply a guideline for completion should you choose to complete these sections.*
Boxes 24h Not a required field.* Do not print the physician/health care provider’s Anthem 24i, 24j, 13-digit number.
24k.

Box 25. Print the number under which you report your earnings, and check the appropriate box that identifies whether it is a federal tax identification number or your social security number.

Box 26. Not a required field.* Use of this box is for the medical office’s use only. If a patient account number is listed here, it will appear on your provider remittance.

Box 27. Not a required field.* Please check the appropriate box for assignment.

Box 28. Print the exact amount of total charges for all services listed on the claim form. Procedures for which there is no charge should not be indicated on the claim form. This box must be completed for the claim to be processed.

Box 29. Not a required field.* Print the exact amount paid by the patient.

Box 30. Not a required field.* Print the exact amount of any balance due to the physician or health care provider.

Box 31. The personal signature of the person who has provided medical care is always required. This applies for both participating and non-participating physicians and health care providers. (This requirement does not apply to physicians and health care providers who sign an Electronic Provider Agreement and submit their claims electronically.)

Box 32. If services were rendered in a location other than the patient’s home or the physician or health care provider’s office, print the name and address of the facility or type in the Facility Code from the appendix section (otherwise leave blank).

Box 33. Print the physician or health care professional’s name, address and 13-digit provider identification number. (It is extremely important to indicate the correct provider identification number to assure that payment is made to the appropriate provider).

• The name and corresponding information for the specific physician or health care provider who rendered the service should be listed.

• If a group of physicians or a corporation is involved, the physician or health care provider’s name should be printed on the first line, and the name of the group on the second line.

• If the provider of service(s) practices in multiple office locations, the appropriate office address where services were rendered should be listed and the corresponding provider number for that location should be used.

• The Anthem 13-digit provider identification number must be printed in this box. Your identification number may be verified through the Provider Call Center. Anthem participating physicians and health care providers: Please do not submit your group identification number (this 13-digit number starts with “50”).

* Completion of this box is not required for claims processing. The information included here on non-required fields is simply a guideline for completion should you choose to complete these sections.
Covering Situations for BlueCare Health Plan Programs

Covering Situations for BlueCare Health Plans that Require a PCP Referral:

- When the member’s identified Primary Care Physician (PCP) is unavailable to provide services and it is necessary for the member to see another physician, information on the covering physician(s) must be provided to the Plan in writing, and entered on system prior to submission of claims for services.

- Participating PCPs are asked to list covering arrangements on their credentialing application. If a PCP’s covering arrangement changes, it is important to notify us in writing concerning these changes.

- If we are not notified of changes to covering arrangements, claims for these services will either deny or be subject to applicable cost shares based on the member’s benefits.

- Please note: in a covering situation, claims should be submitted by the physician rendering the service.

Non-participating Covering Physicians

- The use of participating physicians as covering physicians is encouraged whenever possible.

- For directly contracted physicians, approval to use a non-participating physician as covering will be determined on a case-by-case basis by the plan.

- The use of non-participating physicians as covering physicians differs by various IPA, PHO and other risk sharing arrangements (RSAs); please check with your RSA administrator.

- In the event that a non-participating physician must cover for a participating physician, his/her necessary information must be received in writing, and entered on system prior to rendering services. Please see the "Covering Physician Agreement" in the Forms chapter of this Manual.

- Non-participating physicians used in covering situations must agree to the base fee schedule and abide by plan rules and regulations.

Locum Tenens

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

Administrative Guidelines

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

A. Dates of absence (the request should not exceed a three-month or 90-day substitution period). Unusual absence circumstances will be reviewed case by case.

B. The absent physician’s tax identification and Anthem provider number.

The Locum Tenens will be requested to submit the following:

A. An Anthem modified credentialing application; (see the Forms chapter of this manual)

B. An Anthem agreement statement; and

C. A confirmation of liability insurance with the participating physician.

Anthem will review the completed application and send back approval or denial of the participating provider’s request for substitute physician. After the three-month or 90-day covering period, the substitute physician must apply to become a participating Anthem physician either as a member of that group or as
an individual in order to continue providing in-network medical services to Anthem members, except as otherwise approved by the plan.

**Locum Tenens Claims Submission**

The participating physician will receive a provider number for the substituting physician and receive payment for the substitute physician services under the participating physician’s tax identification number. The participating physician generally pays the substitute physician a fixed amount per diem with the substitute physician having the status of an independent contractor rather than of an employee.

- Payment for covered services shall be made to the participating provider’s tax identification at the contracted rate for the participating provider.
- The participating physician must keep on file a record of each service provided by the substitute physician. This record must be made available to Anthem upon request during normal business hours.

**Provider Remittances**

The numbered items below correspond with the numbers marked on the following sample provider remittance. Please refer to the sample remittance following this description when reviewing these items.

1. Name and address of physician or health care provider who rendered medical services.
2. Number of pages for the provider remittance.
3. Date the provider remittance was issued.
4. 13-digit identification number of the physician or health care provider who rendered medical services.
5. Name of the patient (last name first, first name second).
6. Claim number.
7. Identification number assigned to the claim submitted.
8. Name of the member’s benefit plan.
9. Number the physician/health care provider’s office has assigned to the patient; will be reflected only if submitted in box 26 of the red CMS-1500 claim form.
10. Procedure code(s) describing medical services rendered.
11. Date on which medical services began.
12. Date on which medical services ended.
13. Number reflected in box 24g of the red CMS-1500 claim form; describes the number of days or units related to the medical service.
14. The status of the claim; see box 22 for more information.
15. The amount charged by the physician or health care provider for performing the medical service(s).
16. The amount that Anthem will pay.
17. The amount that has been applied to the member’s deductible.
18. The amount of the copay or the coinsurance for which the member is responsible.
19. Any plan-specific reduction for which the member may be financially responsible.
20. The amount that Anthem will pay.
21. Any amount for which the member is financially responsible.
22. Describes the abbreviations of the status codes reflected in item 14 (see page 15, item 22 on the “Sample Provider Remittance” for a listing of codes).
Remittances

A remittance voucher is sent to participating physicians and health care providers when a remittance check is sent. This voucher identifies claims that are paid, adjusted or denied. Remittance statements are vital tools that should be shared with each of your office sites and should be referenced prior to calling to check a claims status.

Remittances for Paper and Electronic Claims

All paper and electronic claims received are adjudicated and remitted weekly.

If you would like to know more about the benefits of electronic claim submissions, please contact our EDI Support Unit at (800) 922-1742, ext. 8293.

Explanation of Remittance Voucher

The following information can be found on each remittance voucher. Please refer to the “Sample Provider Remittance” on page 16-15.

1. Claims are numbered in sequence to the listing on payment voucher.
2. The number of times the service was rendered.
3. The HCPCS/CPT procedure code used to pay the service.
4. The date service started.
5. The date service ended.
6. The actual charges of the physician or health care provider.
7. Amount paid by Anthem.
8. The amount that can be billed to the patient.
9. The explanation of non-covered services or maximums.
10. This area identifies any adjustments to the total amount.

When payment is made to a physician or health care provider for services rendered to his or her Anthem member, the member also receives notification.
## Sample Provider Remittance

**Claim Filing 16**

**Anthem Blue Cross and Blue Shield**  
**Policies & Procedures Manual**  
**2005 Rev.**

---

### PROVIDER REMITTANCE

**THIS IS NOT A BILL**

A PAYMENT SUMMARY AND AN EXPLANATION OF CODES ARE AT THE END OF THIS STATEMENT

---

### Sample Provider Remittance

<table>
<thead>
<tr>
<th>Procedure</th>
<th>From Date</th>
<th>Thru Date</th>
<th>Status Code</th>
<th>Amount Code</th>
<th>Amount Charged</th>
<th>Amount Allowed</th>
<th>Deductible</th>
<th>Coins</th>
<th>Copay</th>
<th>Other Amount</th>
<th>Patient Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td>9921.00</td>
<td>01/13/94</td>
<td>01/13/94</td>
<td>A</td>
<td>55.00</td>
<td>54.00</td>
<td>.00</td>
<td>5.00</td>
<td>.00</td>
<td>89.35</td>
<td>5.00</td>
<td></td>
</tr>
<tr>
<td>9950.00</td>
<td>01/13/94</td>
<td>01/13/94</td>
<td>A</td>
<td>40.50</td>
<td>39.50</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>39.50</td>
<td>.00</td>
<td></td>
</tr>
<tr>
<td>81000.00</td>
<td>01/13/94</td>
<td>01/13/94</td>
<td>A</td>
<td>8.00</td>
<td>5.85</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>5.85</td>
<td>.00</td>
<td></td>
</tr>
</tbody>
</table>

**Claim Totals:**  
103.50  94.35  .00  5.00  .00  89.35  5.00

**Patient:**  
**Smith**  
**Allan**  
**James**

---

### Payment Summary

<table>
<thead>
<tr>
<th>Total Amount Paid</th>
<th>Amount Charged</th>
<th>Number</th>
<th>Date</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>224.35</td>
<td>294.50</td>
<td>000000000000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Credit Deferred</th>
<th>Deductible</th>
<th>Other Reduction</th>
<th>Amount Approved</th>
<th>Total Credits</th>
</tr>
</thead>
<tbody>
<tr>
<td>000000000000</td>
<td>000000000000</td>
<td>000000000000</td>
<td>000000000000</td>
<td>000000000000</td>
</tr>
</tbody>
</table>

---

**Status Codes:**

- **A** - Approved  
- **AJ** - Adjustment  
- **IP** - In Process  
- **R** - Rejected  
- **V** - Void

---
BlueCare Health Plan Provider Patient Listing/Active Membership Report

BlueCare Health Plan primary care physicians receive a Provider Patient Listing from the plan each month. This is a cumulative report of members eligible for benefits who have selected this provider as their primary care physician. The report includes the following:

A. Member names
B. Member identification numbers
C. Effective dates of registration with this primary care physician
D. Birth Dates
E. Type of BlueCare Program

This report is run monthly and is scheduled to be received in the provider’s office by the first of each month.

Overpayment and Refund Procedures

Anthem makes every effort to process claims promptly and accurately. However, in the event that benefit payments are made in error, refunds should be made to the plan.

When a payment error is recognized, notify us as soon as possible, as outlined below.

BlueCare Health Plan and Century Preferred

Please complete a Medical/Surgical Provider Refund form #1599 to tell us how you would like to refund the overpayment. (A sample form can be found in the Forms section of this manual. Please copy this form as needed. You may indicate on the upper portion of the form that you would like:

• to attach a personal check for the dollar amount overpaid by Anthem Blue Cross and Blue Shield, or
• have the overpayment deducted from future remittances.

Please send the Medical/Surgical Provider Refund form to the address below:

Anthem Blue Cross and Blue Shield
Provider Call Center
P.O. Box 1091
North Haven, CT 06473

If the Anthem check received includes only those monies that must be returned, you may attach that check to a Medical/Surgical Provider Refund form and return it to the address listed above.

BlueCard
Send refunds to:
Anthem Blue Cross and Blue Shield
P.O. Box 1050
North Haven, CT 06473

FEP
Send refunds to:
Anthem Blue Cross and Blue Shield
Financial Operations FEP 5W070
P.O. Box 978
Portland, ME 04104-0978
Ensuring Proper Financial Reporting

To minimize 1099 inaccuracies, please verify the following information when receiving checks from the plan:

**Individual Practices**

- The check is issued in your name, the physician or health care professional who provided medical services.
- The check is issued for medical services you have rendered to the member whose name is on the remittance.
- The provider number on the remittance is issued to you, the physician or health care professional who provided medical services.

**Group Practices**

If you report earnings under a corporate or group tax identification number, the provider number reflected on your remittance should be a separate number established for your group (the first two digits will be “50”). Please verify the following information when receiving compensation:

- The 13-digit provider number on the remittance is issued to the proper “50” provider number.
17. Physician/Provider Compensation

Table of Contents

Provider Compensation.................................................................................................................................................. 2
HMO Plan Compensation............................................................................................................................................... 2
PPO and Indemnity Plan Compensation...................................................................................................................... 2
PCP Quality Incentive Program................................................................................................................................. 3

IMPORTANT NOTE:

Providers participating in our BlueCare Health Plan programs may not balance bill a member when the claim is denied because of lack of medical necessity. Neither Anthem nor the member is responsible for care that is determined to be medically unnecessary. The member can only be balance billed for these services if the provider secures the member’s consent to the care in advance of receiving it, and documents that consent, including the disclosure that the care will not be covered under the member’s health plan.
Provider Compensation

HMO Plan Compensation

Compensation for our BlueCare Health Plan commercial HMO programs varies based on your contract to provide services for plan members.

- **Direct Contracting**: Anthem directly contracts with physicians and other health care professionals to provide services to our BlueCare Health Plan members. See graph below for specific plan.

- **Additional Contracting Arrangements**: We also contract with participating physicians through a variety of Physician/Hospital Organizations (PHOs), Individual Practice Associations (IPAs) and other large contracting entities.

<table>
<thead>
<tr>
<th>BlueCare Health Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Product Name</strong></td>
</tr>
<tr>
<td>BlueCare</td>
</tr>
<tr>
<td>BlueCare Plus</td>
</tr>
<tr>
<td>BlueCare POS</td>
</tr>
<tr>
<td>BlueCare Plus POS</td>
</tr>
<tr>
<td>BlueCare Plus Basic</td>
</tr>
<tr>
<td>BlueCare Plus Direct</td>
</tr>
<tr>
<td>BlueCare Plus NSB</td>
</tr>
<tr>
<td>BlueCare Plus Premier</td>
</tr>
<tr>
<td>BlueCare Plus Access 10</td>
</tr>
<tr>
<td>HMO Blue New England</td>
</tr>
<tr>
<td>Blue Choice New England</td>
</tr>
<tr>
<td>State BlueCare POS</td>
</tr>
<tr>
<td>State BlueCare POE</td>
</tr>
<tr>
<td>State BlueCare Plus POE</td>
</tr>
</tbody>
</table>

PPO and Indemnity Plan Compensation

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Compensation Structure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Century Preferred</td>
<td>Covered services are compensated directly to participating physicians and health care providers according to the then current Comprehensive Schedule of Professional Services or the provider’s charge, whichever is less.</td>
</tr>
<tr>
<td>Century Preferred Comp</td>
<td></td>
</tr>
<tr>
<td>Century 90 programs</td>
<td></td>
</tr>
<tr>
<td>State Preferred</td>
<td></td>
</tr>
<tr>
<td>Comprehensive</td>
<td>Compensation is made directly to the physician or health care provider at typically 80 percent of the allowed amount if the member gives authorization by signing boxes 12 and 13 of the CMS-1500 claim form (physician or health care provider may balance bill the member for the remainder up to the allowed amount); otherwise, compensation is made directly to member. Once out of pocket expenses are met, compensation is at 100 percent.</td>
</tr>
<tr>
<td>Direct Pay</td>
<td></td>
</tr>
<tr>
<td>Group Comprehensive</td>
<td></td>
</tr>
<tr>
<td>Wraparound</td>
<td></td>
</tr>
</tbody>
</table>
**Major Medical**

Major Medical compensation (in standard contracts) is based on 80 percent of the Major Medical maximum allowable amount paid directly to the member for covered services. Payment is made directly to the member.

**Federal Employee Health Benefits**

Covered services are paid directly to participating/preferred physicians and health care providers based on a percentage of the then current *Comprehensive Schedule of Professional Services* or the provider’s charge, whichever is less. *Century Preferred* participating physicians and health care providers may, after collecting any applicable copay and deductible requirements, bill the difference up to the fee schedule amount or the provider’s charge, whichever is less.

**Small Employer Special Health Care Plans**

As mandated by Connecticut state law, compensation for covered services rendered by physicians and health care providers is according to 75 percent of the current Medicare allowance. You may not balance bill the patient for services you render if they are identified as low-income members (NBB on identification card). If they are identified as non-low income members, they may be balance billed up to your charge.

**Small Employer Comprehensive Plan**

As mandated by Connecticut state law, compensation for covered services rendered by participating and preferred physicians and health care providers is at 80 percent, for covered services. Member responsibility is 20 percent. Payment is subject to all applicable deductibles and coinsurance. Coinsurance for outpatient behavioral health treatment is 50 percent.

**Small Employer Hospital/Med. Surg /Major Medical Plan**

As mandated by Connecticut state law, compensation for covered services rendered by participating and preferred physicians and health care professionals is according to the then current *Comprehensive Schedule of Professional Services*. *Century 90* participating physicians and health care providers must accept the allowance as payment in full.

---

**AQA Primary Care Quality Incentive Program**

Primary care physicians and providers in Anthem’s East region are eligible to participate in the Anthem Quality Insights (AQA) Primary Care Quality Incentive Program. More information on this program can be found in the Quality Management chapter of this manual.
# 18. PHYSICIAN/PROVIDER PARTICIPATION REQUIREMENTS

## Table of Contents

- Participating Physician, Provider and Group Agreements ..................................................2
- Credentialing / Recredentialing ........................................................................................................3
- Notification of Changes ....................................................................................................................6
- Provider Self-Insurance Requirements .............................................................................................7
- Physician/Provider HMO ..................................................................................................................7
- Access Goals and Calendar Requirements .....................................................................................7
- 24/7 Coverage Requirements for Par Providers ...........................................................................8
- Hospitalist Programs .......................................................................................................................8
Participating Physician, Provider and Group Agreements

About our Agreements

Your participation with Anthem Blue Cross and Blue Shield commercial plans and programs is determined by your completion and Anthem’s formal acceptance of your Participating Provider Agreement (Group or Solo) and Credentialing Application. To avoid delays in compensation and gaps in participation, it is important that you contact Anthem whenever there is a change in your practice.

- **Participation Confirmation and Effective Dates:** Physicians or providers who have applied for participation should not provide services as a participating provider to members of any Anthem plan or program until such time as he/she receives a formal notification from Anthem that he/she is a participating provider. This notification will specify the effective date of participation and which programs and/or products are included in the participation. Any services provided to members before the effective date will be considered out-of-network services.

- **Defining Solo vs. Group Practices:** Determinations on whether a practice receives a solo or group agreement are based on the following solo provider and group provider criteria:
  - **Solo Providers** are identified as those who provide us with a Social Security or Tax ID Number (TIN) that is tied to their name alone.
  - **Group Providers** are identified as those who provide us with a TIN that is tied to either their name as a PC, LLC or partnership, or to a Group business name.

- **If you practice both as a member of a group and as a solo practitioner,** and you are submitting the Anthem agreement, **you must sign an individual agreement in addition to the group agreement in order to be participating in both arrangements.** A separate agreement is required for each tax ID number under which you are billing.

- **Changing Your Practice:** If a participating physician or provider, or group of providers leaves a participating group practice and joins or forms another group practice, **participation does not automatically continue for those providers.** Depending on the situation, a new Group Agreement and/or Signature Sheet may need to be completed and submitted in order to continue participation in Anthem’s networks with the new group. Services to our members are not eligible for in-network coverage until such time as the physician or provider receives a formal notification from Anthem of his/her participation under the new Group Agreement and the effective date.

- **Keep our Members Up to Date!** Each provider is responsible for informing members about the provider’s participation status with Anthem so members can maximize their benefits and make informed decisions about their care.

- **Adding members to Group Practices:** It is important that new members of group practices promptly apply for participation in order to maintain participation consistency within the practice and ensure that members see network physicians and health care professionals to maximize the value of their health care benefits. **Important note:** A new member of a participating Anthem group is NOT a participating provider until such time as he/she is credentialed, and/or contracted with Anthem, and receives written notification of his/her effective date.

- **Participation through a provider sponsored organization:** In circumstances where Anthem contracts with an IPA, PHO or other provider sponsored organization, you may be required to execute an individual or group agreement with Anthem in addition to your agreement with the contracting organization.

When to Submit an Agreement

An agreement may be submitted to the Provider Relations Department:

- **When a physician, health care professional or provider group chooses to apply for participation in any Anthem network.**
• When a physician or provider in a group practice that is participating in any Anthem network wishes to also maintain a solo practice and retain membership in that network under the solo practice.
• When a physician who has a solo practice or is a member of a group practice wishes to join an IPA, PHO or other provider sponsored organization that has an agreement with Anthem (this may not be required for membership in all such arrangements.)
• **Note:** When a physician or health care provider joins a group practice that is already participating in any Anthem network, that physician or provider must sign a *Represented Provider Certification and Authorization* (signature) Sheet, but does not need to submit an agreement.

### How to Complete an Agreement

When completing an Anthem agreement and associated credentialing form, please be sure you follow the instructions carefully and fill out all required information. Please keep the following “Do’s” and “Do Not’s” in mind:

**Do:**

- **Sign on the appropriate line** (physician or health care professional signature stamps are not acceptable).
- **Submit only original agreements for consideration**; copies of the agreement will not be eligible for processing.
- **Solo Providers:** Include the street address of the primary office location where appropriate (post office boxes without the actual physical address listed are not acceptable).
- **Groups:** Include a signed *Represented Provider Certification and Authorization* (signature) sheet when completing a Group Agreement.

**Do Not:**

- **Use white-out or make cross-outs on the agreement** (the presence of white-out and/or cross-outs will render the agreement unacceptable).
- **Complete a section that is reserved for Anthem use only.**

You may obtain group and solo agreements and credentialing applications by contacting the Provider Call Center at (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven).

### Credentialing / Recredentialing

**Initial Requirements - Credentialing**

Physicians and health care professionals providing services to members in Anthem’s *BlueCare Health Plan* HMO and *Century Preferred PPO* networks must meet Anthem credentialing standards. As part of the credentialing process, each applicant to the HMO network is screened against a set of standards that meet the stringent requirements of the National Committee for Quality Assurance (NCQA).

Our credentialing program allows us to meet the expectations of the marketplace, while helping to ensure practitioners providing services meet minimum credentialing standards. It also helps participating physicians feel confident when referring members to other network specialists.

If a physician or health care professional is joining your practice, he/she must apply for credentialing in the *BlueCare Health Plan* and/or *Century Preferred* networks to be eligible for compensation for in-network services.
The Credentialing Application Process

- All providers applying for initial credentialing must complete a form online through the CAQH Universal Credentialing DataSource Web site (see additional information below).
- More information on CAQH and the credentialing process is available on our Web site, anthem.com, on the Connecticut Provider Page. Just click on Anthem Online Provider Services > scroll down to “Credentialing and Contracting” to access CAQH information.
- For information on how to obtain a CAQH ID number and to be added to Anthem’s CAQH roster, contact the Provider Call Center at (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven) Monday through Friday, 8:15 a.m. to 5 p.m.

The CAQH Credentialing Web site: The Council for Affordable Quality Healthcare (CAQH) is a not-for-profit alliance of 24 of the nation’s largest health plans and their trade associations, including Anthem. CAQH’s Universal Credentialing DataSource is a secure, online database that helps eliminate the need to fill out and submit multiple credentialing applications.

With the innovative CAQH system, each physician or healthcare provider submits just one standard application to a single database that is designed to meet the needs of the health plans participating with the database. Benefits include:

- Providers can easily update their information at anytime, and will be asked every 120 days whether the information on file is complete and accurate. Participating health plans will be automatically notified when the healthcare provider’s information changes.
- Participating health plans can access the credentialing information at any time, as long as the provider has authorized it.
- Individual health plans continue to do the data verification and review, and make an independent decision about whether a provider meets that organization’s standards for participation.
- There is no cost for physicians and other healthcare providers to submit information to the credentialing data collection system.

To learn more about CAQH and view an online demonstration of the credentialing data system, visit the CAQH web site at www.CAQH.org, or speak with your provider relations representative. You may also contact the CAQH Help Desk at (888) 599-1771 for more information.

BlueCare Health Plan HMO Network Credentialing Criteria
Specific credentialing criteria include, but are not limited to:

- A valid, current, unencumbered license in state(s) in which the practitioner practices and participates with Anthem.
- Unrestricted admitting privileges in good standing at a participating BlueCare Health Plan hospital, or demonstration of alternative admitting arrangements that are acceptable to Anthem; A current, valid, unrestricted controlled substance license (DEA-Federal). A practitioner whose DEA is currently limited, revoked or suspended may not be considered for participation.
- A full, unrestricted controlled substance registration certificate (CSR) for practitioners practicing in those states which issue a state-issued drug registration.
- Board certification within six years of completion of training in the specialty in which credentialing is sought.
- A current professional liability policy of not less than $1 million per occurrence and $3 million aggregate

The above criteria are examples of a variety of requirements that Anthem uses in its provider credentialing and selection process. These criteria vary by physician and provider type, and changes from time to time based on input from the medical community and market considerations.

Century Preferred PPO Network Credentialing Criteria
Anthem is in the process of credentialing all the physicians and allied providers who participate in the Century Preferred PPO network.

- All providers new to the network will be credentialed before joining the network.
- All allied providers currently participating in Century Preferred will be credentialed in 2005-2006.
The Credentialing Criteria

The following are examples of credentialing criteria that are applicable to physicians and other providers as a condition of initiating or continuing participation in the Century Preferred PPO network. Please note that all criteria may not be applicable to each provider type:

- A valid, current, unencumbered license in state(s) in which the practitioner practices and participates with Anthem.
- Unrestricted admitting and/or practice privileges, in good standing, at a participating Century Preferred (PPO) or BlueCard hospital for both primary care practitioners and specialists (as applicable), or demonstration of alternative admitting arrangements that are acceptable to Anthem.
- A current, valid, unrestricted controlled substance license (DEA-Federal). A practitioner whose DEA is currently limited, revoked or suspended may not be considered for participation.
- A full, unrestricted controlled substance registration certificate (CSR) for practitioners practicing in those states which issue a state-issued drug registration.
- A current professional liability policy of not less than $1 million per occurrence and $3 million aggregate.

The above criteria are examples of a variety of requirements that Anthem uses in its provider credentialing and selection process. These criteria vary by physician and provider type, and changes from time to time based on input from the medical community and market considerations.

Credentialing Through CAQH

In accordance with the schedule above, all participating Century Preferred providers will receive an invitation from the CAQH (Council for Affordable Quality Healthcare) to file credentialing information with them.

Please see the “About our Agreements” section on the previous page for important participation information.

Ongoing Requirements - Licensing, Recredentialing

As a contracted physician or health care professional, you are a key participant in our health care delivery system helping to promote high-quality, cost effective care to members. Once you are accepted for participation in the network:

- Licenses, board certification, as applicable, and medical malpractice requirements must be maintained.
- Recredentialing is performed at least every 36 months. As part of this process, you will have access to your original credentialing information and you must update and reattest to the documentation in the timeframe indicated.
- Information retrieved from CAQH’s Universal Credentialing DataSource is used to credential and recredential network providers.

As part of the credentialing and recredentialing process, the Plan conducts primary source verification of provider information. This includes, but is not limited to licensing boards, specialty certifying boards and the National Practitioner Data Bank (NPDB).

Additional Credentialing Notes

Providers may, upon request, review any information collected as part of the credentialing verification process, unless such information is confidential under state or federal law.

If a discrepancy or error is identified or further information from the provider is required, a request is sent to the provider outlining the information needed, the method for response and the person to whom the information should be sent. The provider will be given the right to correct any erroneous information.
Providers may obtain a copy of our credentialing criteria upon request. Providers also have a right to inquire about the status of their credentialing application by contacting Anthem’s Network Management or Credentialing Department.

**Notification of Changes**

In accordance with your Participating Provider Agreement* (Group or Solo), participating providers are required to notify Anthem in writing within seven days of the following:

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

* See section E. “Notice of Changes” in your Solo or Group Participating Provider Agreement.
Provider Self-Insurance Requirements

Types and Amounts of Insurance or Self-Insurance:

- Professional/Medical Malpractice: Minimum limit of $1M/$3M
- Commercial General Liability: Minimum limit of $1M/$3M

Physician/Provider HMO
Access Goals and Calendar Requirements

Anthem has adopted access goals and calendar access requirements for our HMO participating provider network. These guidelines were developed in accordance with national managed care standards and with input from physicians across Connecticut represented on our consultant panels.

Plan-wide Access Goals:
One of our goals is to make accessing medical care easy for members by assuring a comprehensive network of physicians and providers close to their homes. As a result, we have implemented the following plan-wide geographic access goals as guidelines for our HMO network. It is our goal to provide members with access to the following within our defined service areas:

- Two PCPs within eight miles of each member
- Two OB/GYNs within eight miles of each member
- A full range of specialists (including non-MD allieds) within 15 miles of each member

Calendar Access Requirements:
In addition, we have adopted the following calendar access requirements for appointment scheduling for HMO participating physicians and specialists:

Primary Care Physicians
- In-office waiting time - 30 minutes.
- Initial/preventive appointment within six weeks.
- Routine appointment for symptoms within five working days.
- Urgent care within one day.
- Emergency care available on a 24-hour per day, seven days per week basis or arranged for as approved by the Plan.
- After-hours coverage is required by the provider agreement.

Participating Specialists
- In-office waiting time - 30 minutes.
- Initial non-urgent appointment within six weeks.
- Acute symptoms within one day.
- Emergency care available on a 24-hour per day, seven days per week basis or arranged for as approved by the Plan.
- After-hours coverage is required by the provider agreement.

Timely access to physicians is a major priority of our members and employers. The requirements adopted reflect not only their expectations, but market norms. We will be assessing physicians against these requirements as a part of our site visits and through our customer satisfaction surveys. However, we are sensitive to problems related to seasonal services, the varying nature of practice specialties and the challenges faced by busy practices. Should your office routinely exceed these targets, it is important that you document and we understand the reasons that the requirements were not met.
24/7 Coverage Requirements for Par Providers

In accordance with your Anthem Participating Provider Agreement: “To assure continuity of care for Members, the Provider shall provide necessary services to Members on a 24-hour per day, seven-day per week basis or arrange for emergency coverage as approved by Anthem Blue Cross and Blue Shield”.

- Participating practices must afford physical or verbal provider accessibility 24/7.
- Anthem recognizes that individual providers may not be available 24/7 for coverage of their own practices. However, when they are unavailable, provider(s) of a similar specialty must be covering for their patients.

**Telephonic (24/7) coverage, as a means by which a member can contact his/her provider or covering provider for non-life-threatening emergencies, is acceptable as follows:**

- Answering service
- Voice mail directing a member to another telephone accessible by the provider, or an answering service
- Cell phone, but only if the cell phone has a voice mail instruction directing members to call an answering service if the cell phone is not answered. Digital cell phone technology is encouraged to help protect member confidentiality.

Telephonic answering machines and voicemail are not acceptable means of providing member access if the answering machine/voicemail **only** refers members to the Emergency Room, to call 911, or leave a message for a call back later

**Hospitalist Programs**

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

**Information to be Supplied by Requesting Facility:**

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

**Requirements for Participation in an Anthem Contracted Hospitalist Program:**

- Hospitalists must be credentialed by the hospitals as full-time hospital employees with no community-based practices. They are not selected by Anthem members as PCPs and are not listed in Anthem provider directories.
- Hospitalists must have current American Board of Medical Specialty (ABMS) or American Osteopathic Association (AOA) board certification in internal medicine or family practice OR must be eligible to take the applicable certifying examination and achieve full board certification within the time period required by the applicable hospital medical staff bylaws. If there is no such
hospital requirement, board certification must be obtained within two years of becoming a participating hospitalist with Anthem.

- The hospital or contracting entity must sign an Anthem Hospitalist Participating Provider Group Agreement.
- Each hospitalist wishing to participate with Anthem in this contracted program must sign a Represented Provider Certification and Authorization Form.
- Each hospitalist must complete and sign a Hospitalist Provider File Information Form completed by each hospitalist.
- Prior authorization (if required) is the responsibility of the hospitalist physician who admits the member.
- All claims for hospitalist professional services must be submitted on CMS-1500 claim forms under the hospitalist’s name and provider number.
- Hospitalists provide and bill for inpatient services only.
- Covered services are subject to fees established for the applicable institution or program, whichever is applicable.

Clinical Program Requirements:

- Clinical program is offered only for medical (non-surgical) admissions.
- The inpatient attending physician of record for a member must be a hospitalist who participates in an Anthem approved program.
- Prior to admission, the member must be informed about the hospitalist program. He/she must be given the choice of selecting an inpatient attending physician (hospitalist service) or his/her primary care physician.
- Communication between the hospitalist and the member’s PCP is required at the time of admission, during the hospitalization, as needed, and at the time of discharge.
- When it has been determined by the hospitalist, patient (and family, if applicable), that hospital discharge is appropriate, the physician will inform all appropriate hospital staff, e.g. discharge planners, etc. to arrange for timely discharge. Discharge planners will facilitate all appropriate supplemental outpatient services, e.g. home care arrangements/transfers to other facilities.
- The hospitalist will communicate with the PCP within 24-hours of discharge to discuss the hospital course, discharge plans and needed follow-up, including pending results of diagnostic testing.
- The discharge process includes providing all clinical services to facilitate a safe discharge, applicable physician orders and documentation in the hospital record, and completion of all forms necessary for safe discharge. Examples of the above are listed below:
  - Daily clinical rounds
  - Review of all consultant reviews and recommendations
  - Follow-up on all pending diagnostic/therapeutic test results
  - Documentation of discharge orders, including follow-up on pending tests or clinical appointments
  - Consultation with discharge planners, if needed
  - Discharge summary dictation (copied to the PCP as well)
  - Completion of all necessary forms, e.g. ambulance transfer, VNA referral, another facility transfer ("W-10 form")
## 19. APPEALS PROCESS

### Table of Contents

- **Member / Provider Appeal Process**
- **Participating Provider Appeals of Sanctions**
  - I. Purpose
  - II. Policy
  - III. Procedure
- **Participating Provider Appeals of Audit Decisions**
- **Policy and Procedure**
- **Physician and Health Care Professional Audit Process**
- **Corrective Action Process**
Member / Provider Appeal Process

(7/05 rev.)

Questions may be posed about the member's health benefit plan. Since most questions can be handled informally, these questions should be addressed by contacting Member Service/Customer Service utilizing the telephone number provided on the back of the member's identification card, while participating providers should call (800) 922-3242. In addition, information about the following Appeal process may be obtained by contacting Member Service/Customer Service.

The Appeal process is available to the member, the provider, or the duly authorized representative of the member or provider. This Appeal process applies to any adverse utilization review determination (which is considered an adverse pre-service claim determination) or any adverse non-utilization review determination (which is considered an adverse post-service claim determination) that involves a denial, reduction or termination of, or a failure to make payment to or on behalf of a member, in whole or in part, for a benefit under the member's health benefit plan. Utilization review determinations, such as prior authorization or concurrent review, are determinations where receipt of a benefit, in whole or in part, is conditioned upon approval of the benefit in advance. Non-utilization review determinations concern issues relating to the member's health benefit plan such as eligibility for benefits, coverage of claims, or claims processing.

FIRST LEVEL APPEAL

If a determination is not satisfactory, this is considered an adverse utilization review determination or an adverse non-utilization review determination and a First Level Appeal review may be requested. The First Level Appeal review request can be initiated orally, electronically or in writing within one hundred eighty (180) days from the date that the initial adverse utilization review determination or the adverse non-utilization review determination is received. Written First Level Appeal review requests should be mailed to:

Anthem Blue Cross and Blue Shield
First Level Appeal Review
370 Bassett Road, P.O. Box 1038
North Haven, CT  06473-4201

A First Appeal review request should include copies of any additional documentation supporting the Appeal. A First Level Appeal determination will be issued, in writing, within fifteen (15) days from the date that the First Level Appeal review request is received regarding an adverse utilization review determination or within thirty (30) days from the date the First Level Appeal Review request is received regarding an adverse non-utilization review determination. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written determination will state the decision; the specific reason(s) for the decision with reference to the specific health benefit plan provisions on which the decision is based, if applicable, and general information about the next step in the Appeal process.

If the First Level Appeal determination regarding an adverse utilization review determination is not satisfactory, a member of a fully insured health plan or a self-insured governmental health plan which is not subject to the Employee Retirement Income Security Act of 1974 (ERISA), who is diagnosed with a condition that creates a life expectancy of less than two years and the denial is based on the grounds that the proposed service is experimental, may seek information (including the application) regarding an external appeal process administered by the Insurance Department without completing the Second Level Appeal review request through Anthem Blue Cross and Blue Shield.

SECOND LEVEL APPEAL

If the First Level Appeal determination is not satisfactory, a Second Level Appeal review may be requested. The Second Level Appeal review request can be initiated orally, electronically or in writing to the Second Level Appeal Panel within sixty (60) days from the date that the First Level Appeal
determination is received regarding an adverse utilization review determination or within ten (10) days from the date that the First Level Appeal determination is received regarding an adverse non-utilization review determination. At this time, an in-person presentation, telephonic conference, videoconference or conference via other form of acceptable technology may be requested. If the Second Level Appeal review request regarding an adverse non-utilization review determination is received by Anthem Blue Cross and Blue Shield more than ten (10) days from the date that the First Level Appeal determination is received, the time period in excess of that ten (10) days will be considered a request for an extension by the member. Such an extension shall be granted for a period of up to sixty (60) days from the date that the First Level Appeal determination is received. Written Second Level Appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield  
Second Level Appeal Panel  
370 Bassett Road, P.O. Box 1038  
North Haven, CT 06473-4201

A Second Level Appeal review request should include copies of any additional documentation supporting the Appeal. A Second Level Appeal determination will be issued in writing within fifteen (15) days from the date that the Second Level Appeal review request is received regarding an adverse utilization review determination or in writing within twenty (20) days from the date that the Second Level Appeal review request is received regarding an adverse non-utilization review determination. The written determination will be issued within five (5) business days from the date the Appeal decision is made. The written determination will state the decision; the specific reason(s) for the decision with reference to the specific health benefit plan provisions on which the decision is based, if applicable, and general information about the next step in the Appeal process.

LEGAL RIGHTS

If the member’s health benefit plan is sponsored by the member’s employer, and is subject to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), and the member is dissatisfied with any decision after the Second Level Appeal determination is rendered, the member has a right to bring a civil action under §502 (a) of ERISA.

OTHER MEMBER RIGHTS

- In the event of an emergency or life-threatening situation, or when a claim involves urgent care, or when a member who is diagnosed with a condition that creates a life expectancy of less than two years and the denial is based on the grounds that the proposed service is experimental, an Expedited First or Second Level Appeal review may be requested. A determination will be issued within one (1) business day from the date the expedited First or Second Level Appeal review request is received.

- The member is entitled to receive upon request and free of charge, reasonable access to, and copies of, any documents, records, and other information relevant to the member’s claim for benefits.

- If an internal rule, guideline, protocol, or other similar criterion is relied upon in making the adverse utilization review or non-utilization review determination, the specific rule, guideline, protocol, or other similar criterion will be provided to the member free of charge upon request.

- If the adverse determination is based on a medical necessity, or experimental treatment, or other similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination applying the terms of the health benefit plan to the member’s medical circumstances will be provided free of charge upon request.

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

- After completion of both the First and Second Level Appeals for an adverse utilization review determination or an adverse non-utilization review determination based on medical necessity, a member, the provider or the duly authorized representative of the member or provider for a
member of a fully insured health plan may seek information (including the application) regarding an external appeal process administered by the Insurance Department by contacting: State of Connecticut, Insurance Department, P.O. Box 816, Hartford, CT 06142-0816 or by calling (860) 297-3910. An external appeal must be submitted to the State of Connecticut Insurance Department within thirty (30) days from the date of the Second Level Appeal determination.

- The member, the provider, or the duly authorized representative of the member or provider may, at any time, seek further review of an adverse determination by writing to the Insurance Commissioner at: State of Connecticut, Insurance Department, Consumer Affairs, P.O. Box 816, Hartford, Connecticut 06142, or by calling (860) 297-3910.

**Participating Provider Appeals of Sanctions Policy and Procedure**

**I. Purpose**

The following identifies and describes the policy and procedure associated with participating provider appeals of any decision by Anthem Blue Cross and Blue Shield to terminate for cause the participation agreement with a participating provider or to summarily suspend for cause such a participating provider's network participation (the "Appealable Action"). This policy and procedure applies only to participating providers under direct contract with Anthem Blue Cross and Blue Shield. This policy and procedure shall not apply to (i) any termination that is on the grounds of the provider's fraud or payment or claim abuses against Anthem Blue Cross and Blue Shield; (ii) any termination that is without cause; or (iii) any termination if the terminated agreement specifies a different method of appeal to the terminated provider.

**II. Policy**

It is the policy of Anthem Blue Cross and Blue Shield to deal fairly with its participating providers. If a participating provider is no longer allowed to continue participation in an Anthem Blue Cross and Blue Shield provider network for reasons related to cause under the terms of that provider's participation agreement, then the provider may appeal such decision in accordance with the following procedure.

**III. Procedure**

**Request for Hearing**

If a participating provider is aggrieved by an Appealable Action, the participating provider may request in writing a Hearing as described below. The request for a Hearing (Notice of Appeal) must be submitted to the Anthem Blue Cross and Blue Shield Medical Director within thirty (30) days following the participating provider's receipt of notice of Anthem Blue Cross and Blue Shield's Appealable Action. Anthem Blue Cross and Blue Shield's notice of Appealable Action to a participating provider shall include a copy of this Policy and Procedure.

The Anthem Blue Cross and Blue Shield Medical Director shall schedule a Hearing to occur not more than twenty (20) business days after receipt of the participating provider's Notice of Appeal unless the participating provider agrees to a Hearing at a later date or unless a Panel cannot reasonably be convened within such twenty (20) business days through no fault of Anthem Blue Cross and Blue Shield. Notice of the time and place of the Hearing as well as a list of witnesses expected to testify on behalf of Anthem Blue Cross and Blue Shield shall be
given to the participating provider at least ten (10) business days prior to the date scheduled for the Hearing.

If the participating provider fails to appear at the Hearing or if the participating provider fails to file a timely Notice of Appeal, the participating provider shall be deemed to have waived his or her rights to the Hearing and to any subsequent appellate review; provided, however, that the Panel may, for good cause, continue the Hearing. Good cause shall not include any circumstances reasonably avoidable by the participating provider.

Composition of the Panel

The Hearing Panel (the "Panel") shall consist of three (3) individuals who are appointed by Anthem Blue Cross and Blue Shield. None of the individuals selected shall have participated directly in the Appealable Action. At least one of the individuals shall be a member of the Anthem Blue Cross and Blue Shield Medical Policy Council or any specialty panel reporting to the Medical Policy Council who is not in direct economic competition with the participating provider.

Provider's Rights at Hearing

At a Hearing before the Panel, the participating provider shall have the following rights:

1. To present all reasonably relevant information, as determined by the Chairperson of the Panel, regardless of its admissibility in a court of law;
2. To call witnesses on the provider's behalf and to examine and cross-examine witnesses called by any participant;
3. To be represented by a person or entity of the provider's choice, provided that the provider gives notice of the name of such representative to the Chairperson of the Panel at least five (5) business days prior to the Hearing date; and
4. To make, at his or her discretion, opening and closing statements, and to submit a written statement at the close of the Hearing or within such reasonable time period subsequent thereto as may be determined by the Panel.

Conduct of Hearing

1. Anthem Blue Cross and Blue Shield shall provide the Panel with a record of Anthem Blue Cross and Blue Shield's grounds for the Appealable Action as soon as practicable after the Panel is appointed. Anthem Blue Cross and Blue Shield shall also designate a representative(s) to be present at the Hearing, to answer questions from the Panel or the participating provider regarding the Appealable Action. Such representative(s) shall have, on behalf of Anthem Blue Cross and Blue Shield, the same rights as the participating provider as provided above.
2. The Hearing shall be conducted fairly, but shall be informal and not conducted strictly according to judicial rules relating to the examination of witnesses or presentation of evidence. All reasonably relevant information, as determined at the discretion of the Chairperson, shall be heard or accepted as exhibits. The Chairperson of the Panel shall preside over the Hearing, rule upon matters of procedure, assure that all participants have a reasonable opportunity to present information and shall maintain decorum, and be responsible for the preservation of all documentation that is submitted.

Panel Decision

Within fifteen (15) days following the Hearing, the Panel shall render a written opinion on the matter. The participating provider shall be entitled to a copy of such written opinion. The Panel shall determine solely whether Anthem Blue Cross and Blue Shield fairly followed its policies and procedures in taking the Appealable Action and whether the information that
Anthem Blue Cross and Blue Shield relied upon in reaching the decision that was the basis of the Appealable Action was reasonably reliable.

If the decision of the Panel is adverse to Anthem Blue Cross and Blue Shield, then Anthem Blue Cross and Blue Shield shall rescind the termination for cause or the summary suspension for cause that was the subject of the Appealable Action.

Participating Provider Appeals of Audit Decisions
Policy and Procedure

I. Purpose

The following identifies and describes the policy and procedure associated with a participating provider's appeal of any finding or decision resulting from an audit of the provider's records by Anthem Blue Cross and Blue Shield (Anthem). This policy and procedure applies only to participating providers under direct contract with Anthem. (This Policy and Procedure also applies to participating providers who entered into contracts prior to September 1, 1995 with Constitution HealthCare Inc. and/or BlueCare Health Plan.) This Policy and Procedure shall not apply to (i) an audit decision if the participating provider's agreement specifies a different method of appeal; (ii) an audit decision with respect to which the participating provider has surrendered any right of appeal in a written release, waiver, settlement agreement or other agreement with Anthem; or (iii) preliminary audit results of findings that are not set forth in a Final Audit Letter from Anthem to the participating provider.

II. Policy

It is the policy of Anthem to deal fairly with a participating provider. If an audit of the participating provider's records result in a written finding or decision set forth in a Final Audit Letter from Anthem to the provider, that is adverse to the participating provider, then the provider may appeal such finding or decision in accordance with the following procedure (the "Appeal").

III. Procedure

Request for Hearing

If a participating provider is aggrieved by a written finding or decision set forth in a Final Audit Letter, the participating provider may request in writing a Hearing as described below. The request for a Hearing ("Notice of Appeal") must be sent certified mail, return receipt requested, to Donald Moore, Senior Manager, Anthem East Regional Special Investigations Units within thirty (30) days following the date of the Final Audit Letter. Anthem's Final Audit Letter to a participating provider shall include a copy of this Policy and Procedure. The provider's Notice of Appeal must describe with specificity the issues and amounts that are the subject of the provider's appeal.

The Senior Manager, Anthem East Regional Special Investigations Units or his/her designee shall schedule a Hearing to occur not more than sixty (60) days after receipt of the participating provider's Notice of Appeal, unless the participating provider agrees to a Hearing at a later date or unless a Panel cannot reasonably be convened within such sixty (60) days through no fault of Anthem. Notice of the time and place of the Hearing as well as a list of witnesses expected to testify on behalf of Anthem shall be given to the participating provider not less than fifteen (15) business days prior to the date scheduled for the Hearing.

Within five (5) business days of the participating provider's receipt of Anthem's witness list, the provider shall provide to Anthem the name, address and telephone number of any witnesses,
including expert witness(es), that the provider expects to testify in his, her, or its behalf, as well as the qualifications of any expert and a summary of any expert's opinion relating to the subject matter of the Appeal.

If the participating provider fails to file a timely Notice of Appeal, or to provide the information concerning witnesses, or to appear at the Hearing, then the participating provider shall be deemed to have waived the right to the Hearing and to any subsequent appellate review of any and all matters set forth in the Final Audit Letter; provided, however, that the Panel may, for good cause, continue the Hearing. Good cause shall not include any circumstances reasonably avoidable by the participating provider.

Composition of the Panel

The Hearing Panel (the "Panel") shall consist of three (3) individuals who are appointed by the Senior Manager, Anthem East Regional Special Investigations Units or his/her designee. None of the individuals selected shall have participated directly in any audit decision or finding that is the subject of the Appeal. At least one of the individuals shall be a member of the Anthem Medical Policy Council, or any specialty panel reporting to the Medical Policy Council, who is not in direct economic competition with the participating provider. The Panel members shall designate one of them as a Chairperson.

Provider's Rights at Hearing

At a Hearing before the Panel, the participating provider shall have the following rights:

1. To present all reasonably relevant information, as determined by the Chairperson of the Panel, regardless of its admissibility in a court of law.

2. To call witnesses on the provider's behalf and to examine and cross-examine witnesses called by any participant at the hearing.

3. To be represented by a person or entity of the provider's choice, provided that the provider gives notice of the name of such representative to the Chairperson of the Panel at least ten (10) business days prior to the Hearing date; and

4. To make, at his or her discretion, opening and closing statements, and to submit a written statement at the close of the Hearing or within such reasonable time period subsequent thereto as may be determined by the Panel.

Conduct of Hearing

1. Anthem shall provide the Panel with substantiation of the findings and decisions set forth in the Final Audit Letter that are the subject of the participating provider's Appeal as soon as practicable after the Panel is appointed. Anthem shall also designate a representative(s) to be present at the Hearing, to answer questions from the Panel or the participating provider regarding the issues that are the subject of the Appeal. Such representative(s) shall have, on behalf of Anthem, the same rights as the participating provider as provided above.

2. The Hearing shall be conducted fairly, but shall be informal and need not be conducted strictly according to judicial rules relating to the examination of witnesses or presentation of evidence. All reasonably relevant information, as determined at the discretion of the Chairperson, shall be heard or accepted as exhibits. The Chairperson of the Panel shall preside over the Hearing, rule upon matters of procedure assure that all participants have a reasonable opportunity to present information, maintain decorum, and be responsible for the preservation of all documentation that is submitted.
Panel Decision

Within fifteen (15) business days following the Hearing, or following the receipt of any materials the Panel requested or allowed to be submitted after the hearing, the Panel shall render a written opinion on the matter. The participating provider shall be entitled to a copy of such written opinion. The Panel shall determine whether there was substantial information to support the findings of Anthem.

Based on this determination, the Panel may uphold Anthem’s findings and decisions in whole or in part or it may reverse Anthem’s findings and decisions in whole or in part. The Panel’s written opinion shall also specify the amount of money, if any, that the participating provider owes to Anthem or that Anthem owes to the participating provider on account of provider services either rendered to Anthem members or billed by the participating provider to Anthem.

If the decision of the Panel is adverse to Anthem in any respect, then Anthem agrees to abide by the decision of the Panel pending any further review, in a court of law or otherwise, that Anthem may be elect to pursue.

Physician and Health Care Professional Audit Process

In an effort to enhance the partnership among physicians, health care providers, employer clients, members and the plan, Anthem routinely conducts physician and health care provider audits. It is the responsibility of Anthem to ensure that claims correctly reflect performed services, that the services are billed accurately, and that participating physicians and health care providers comply with the provisions of their contracts with Anthem.

It is our goal to conduct audits with minimal inconvenience to physicians and health care providers. However, the process requires that physicians and health care professionals provide medical and financial records for the members we request. To assist in this process, we will photocopy/microfilm these materials at your location and review records at our corporate headquarters. In all cases, confidentiality will be maintained. The following is a general overview of the process:

- An Anthem auditor will contact your office by telephone to set a mutually agreeable date and time within two weeks of the call for a physician/provider audit.
- Anthem auditors are thoroughly trained and experienced professionals, with a broad knowledge of CPT and ICD-9 coding, Anthem policies and procedures, and Connecticut State statutes.
- You will receive written confirmation of the appointment from the auditor.
- The auditors will bring all necessary equipment to photocopy and/or microfilm the required information from your files.
- You will be given a list of members for whom medical record information is needed, based on claim information that you have submitted. You will be asked to provide the members’ applicable medical records for the period specified by the auditor. This would include, but is not limited to, all offices and progress notes, travel cards, laboratory test results, referrals, requisitions, x-rays, patient sign-in sheets, the office appointment book and accounts-receivable data.
- Claim information and documentation obtained during the visit will be taken back to Anthem corporate headquarters and reviewed by the auditor and Anthem medical professionals.
- Upon completion of the audit, a Preliminary Audit Letter will be sent to you. You will then be given the opportunity to respond to any items indicated as areas of concern.
- Any further information you provide in response to our Preliminary Audit Letter will be considered in conjunction with the original information gathered. The results of this final review will be communicated to you in a Final Audit Letter. If you disagree with the finding in the Final Audit Letter, you will be afforded the opportunity to appeal the audit decision via Anthem’s formal audit appeals process (see the Appeals/Grievance section of this manual).

Questions regarding the audit process may be addressed to your provider relations representative.
Corrective Action Process

Purpose:

Anthem Blue Cross and Blue Shield is committed to promoting services to members by participating physicians and health care providers that are in accordance with the plan’s participation agreements, credentialing/recredentialing criteria, utilization and clinical quality guidelines, and administrative policies and procedures. To this end, the Corrective Action Process provides a consistent means for the plan to identify deficiencies or problems to the participating physician or health care provider so that he/she may adopt corrective measures. Anthem is not obligated to follow this process in every circumstance, nor does the adoption of this process enlarge or expand any obligations of the Company under its participating physician and provider agreements. Likewise, this process does not enlarge the rights of any participating physicians or providers and does not reduce or eliminate any rights of Anthem.

General Description

When an issue is identified that appears to be in conflict with plan policies or guidelines, Anthem Blue Cross and Blue Shield may institute the Corrective Action Process to positively impact practice patterns and/or to effect compliance with contract requirements or administrative guidelines. Physicians and health care providers are afforded the opportunity to submit responsive input as part of this Process. Once Anthem initiates the Corrective Action Process, data is monitored to assure the issue has been successfully resolved.

Investigational Phase

The first level of the process is called the Investigational Phase. When Anthem identifies an issue that appears to be in conflict with Company requirements, policies or guidelines, the Company investigates the issue(s) and any related circumstances. If the investigation indicates that correction should occur, Anthem notifies the physician or health care provider of the issue(s) or concern(s) by letter, phone call or visit.

The physician or health care provider is afforded the opportunity to respond to this notification and, when specifically identified, must reply in writing to Anthem within thirty (30) days of the Company’s notice to the provider. If the plan finds that the response satisfactorily addresses the concern(s), the Corrective Action Process is closed. If the plan does not receive a response from the physician or health care provider, or if the response does not satisfactorily address the issue(s) or concern(s), the Company may initiate Level I of the Corrective Action Process.

Level I

Level I of the Corrective Action Process is an educational stage which may include notification, monitoring and tracking of the issue(s). At this level, the plan identifies the improvements required and provides a timeline for resolution, typically from three to six months.

Anthem continues to monitor and review the issue(s) or concern(s) for the designated time period to determine if the provider corrects the problem(s). If the issue(s) is successfully resolved, the physician or health care provider is removed from the Corrective Action Process and will receive notice to that effect. The Company will periodically review the physician or health care provider to verify that the provider’s correction continues.

If improvement is not shown during Level I, the Company notifies the physician or health care provider who may respond in writing to the Company within thirty (30) days. If the plan finds that the response satisfactorily addresses the concern(s), the Corrective Action Process is closed. If the plan does not receive a response from the physician or health care provider, or if the response does not satisfactorily address the issue(s), the Company may initiate Level II of the Corrective Action Process.
Level II

At Level II of the Corrective Action Process, the Quality Steering Committee reviews the issues and recommends actions to be taken. The Quality Steering Committee consists of Anthem personnel at the manager level or above, and includes a medical director. The plan may initiate Level II of the Corrective Action Process when there is no response or an inadequate response to a Level I notice to the provider, or when the provider fails to comply with a corrective action plan. In these circumstances, the plan notifies the physician or health care provider, who has the opportunity to respond in writing to Anthem within ten (10) business days of the plan’s notice. If the plan finds that the response satisfactorily addresses the concern(s), the Corrective Action Process is closed. If the plan does not receive a response from the provider, or if the response does not satisfactorily address the issue(s), the plan may initiate Level III of this Corrective Action Process.

Level III

At Level III of the Corrective Action Process, the case is presented to the Anthem Contracting Committee for final determination and action. The Contracting Committee may take any action permitted under the applicable Anthem participation agreement, including termination of the agreement.

Where applicable, the physician or health care professional may appeal an adverse decision of the Contracting Committee according to the Company’s appeals processes, outlined in the Anthem Policies and Procedures Manual.
20. FORMS

Table of Contents

♦ Acute Visit Form
♦ Adolescent Comprehensive Exam Form
♦ Adult Comprehensive Physical Exam (CPE) Form
♦ Adult Health Maintenance Form (2 pages)
♦ Ages Birth -2 Years Comprehensive Exam Form
♦ Ages 2-6 Years Comprehensive Exam Form
♦ Ages 7-12 Years Comprehensive Exam Form
♦ Change in Office Form (2 pages)
♦ Covering Physician Agreement
♦ Locum Tenens Credentialing Questionnaire & Required Letter (5 pages)
♦ Medical/Surgical Provider Refund Form
♦ Patient Information Form
♦ Provider Feedback Survey
♦ Member Self-Referral Acknowledgment
### ACUTE VISIT

<table>
<thead>
<tr>
<th>Date</th>
<th>Time</th>
<th>Phone</th>
<th>Patient Name &amp; Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>Wt.(Kgs/lbs)</th>
<th>Temp.</th>
<th>Pulse</th>
<th>Resp.</th>
<th>B/P</th>
<th>/</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Current Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>NKA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Immunization</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>PMH/Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### HISTORY

<table>
<thead>
<tr>
<th>General Condition</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
</tr>
<tr>
<td>Eyes</td>
<td></td>
</tr>
<tr>
<td>Ears/TMS</td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
</tr>
<tr>
<td>Mouth/Throat</td>
<td></td>
</tr>
<tr>
<td>Neck/Nodes</td>
<td></td>
</tr>
<tr>
<td>Chest/Lungs</td>
<td></td>
</tr>
<tr>
<td>Heart/Pulses</td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
</tr>
</tbody>
</table>

#### PHYSICAL EXAM

#### ASSESSMENTS

<table>
<thead>
<tr>
<th>F/U</th>
<th>Sig.</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Treatment & Procedures

<table>
<thead>
<tr>
<th>XRAY</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBC</td>
</tr>
<tr>
<td>ESR</td>
</tr>
<tr>
<td>CRP</td>
</tr>
<tr>
<td>Lytes</td>
</tr>
<tr>
<td>Panel</td>
</tr>
<tr>
<td>Bili</td>
</tr>
<tr>
<td>U/A</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>
# ADOLESCENT COMPREHENSIVE EXAM

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name &amp; Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Allergies</th>
<th>Current Medication</th>
</tr>
</thead>
<tbody>
<tr>
<td>□ NKA</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>PMH/Illness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## History

<table>
<thead>
<tr>
<th>Health</th>
<th>Education/Social</th>
<th>Sexuality</th>
<th>Safety</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grade</td>
<td>Performance</td>
<td>Sex Education</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Family Interaction</td>
<td>STD Prevention</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Friends</td>
<td>Sexual Activity</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Interaction</td>
<td>Protection/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Peer Pressure</td>
<td>Contraception</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Self Esteem</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Future Plan</td>
<td></td>
</tr>
</tbody>
</table>

## Physical Exam

<table>
<thead>
<tr>
<th>General Condition</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Head</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eyes/Vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ears/TMS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nose</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mouth/Throat/Teeth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neck/Nodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lungs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abdomen</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Genitalia/Tanner</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ext./Spine/Scoliosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neuromuscular</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Assessment Plan

<table>
<thead>
<tr>
<th>F/U</th>
<th>Wks / Mos</th>
<th>Sig.</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

## Immunization

<table>
<thead>
<tr>
<th>Td</th>
<th>MMR</th>
<th>Hep-B</th>
<th>VZV</th>
<th>PPD</th>
<th>Rubella (Female)</th>
<th>Mumps (Male)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Vision</th>
<th>Hearing</th>
<th>Urine dip / U/A</th>
<th>CBC / Hemogram</th>
<th>** Lipid Screen</th>
<th>RPR</th>
<th>Cultures: Gonococci</th>
<th>Chlamydia</th>
<th>Vaginal Smear</th>
<th>Pap Smear</th>
<th>** HIV</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* if indicated/not immune
** if at risk
## Adult Comprehensive Physical Exam (CPE)

<table>
<thead>
<tr>
<th>Date: ____________________</th>
<th>Patient Name: ______________________________________________</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOB: ____________________</td>
<td>Ht. _________ Wt. _________ B/P <strong><strong><strong>/</strong></strong></strong> T ______ P ______ R ______</td>
</tr>
<tr>
<td>Allergies: _______________________________</td>
<td>NKA</td>
</tr>
</tbody>
</table>

### Reason for Visit:

Updated Medical/Family/Social History:

### ROS

<table>
<thead>
<tr>
<th>HEENT</th>
<th>Resp</th>
<th>CV</th>
<th>GI/GU</th>
<th>Neuro</th>
<th>Musc/Skel</th>
<th>Endocrine</th>
<th>Other</th>
</tr>
</thead>
</table>

### Physical Examination

<table>
<thead>
<tr>
<th>General Appearance</th>
<th>Skin</th>
<th>Eyes</th>
<th>ENT</th>
<th>Chest/Lungs</th>
<th>Heart</th>
<th>Abdomen</th>
<th>GU/Rectal</th>
<th>Musc/Skel</th>
<th>Neuro/Psych</th>
<th>Other</th>
</tr>
</thead>
</table>

### Assessment:

Plan of Care:

Lab & Dx Tests: | Medications Ordered:

---

(Provider Signature)
# ADULT
## HEALTH MAINTENANCE RECORD

**Name:** _________________________________  **Date of Birth:** ___________________

<table>
<thead>
<tr>
<th><strong>Family History</strong></th>
<th><strong>Social History</strong></th>
<th><strong>Past Medical History</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother:</td>
<td>Smoking:</td>
<td>Medical:</td>
</tr>
<tr>
<td>Father:</td>
<td>Alcohol/Drugs:</td>
<td>Surgical:</td>
</tr>
<tr>
<td>Siblings:</td>
<td>Exercise/Diet:</td>
<td>Accidents:</td>
</tr>
<tr>
<td>G. P.:</td>
<td>Work:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Caffeine:</td>
<td></td>
</tr>
</tbody>
</table>

### Health Screening/Counseling

<table>
<thead>
<tr>
<th>Procedure</th>
<th>18-39</th>
<th>40-49</th>
<th>50-64</th>
<th>&gt; 65</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Complete History &amp; P.E.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pap Test:</td>
<td>Q year: after 3 normal tests then Q 1-3 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mammography:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q 1-2 Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Breast Exam (CBE)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Q 1-2 Years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fecal Occult Blood Test (FOBT)</td>
<td></td>
<td></td>
<td>Q Year</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td></td>
<td></td>
<td>Q 3-5 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cholesterol</td>
<td></td>
<td></td>
<td>Q 5 Years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol/Substance Abuse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic/PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic/PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/STD Prevention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic/PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accident Safety</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic/PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diet Instruction/Exercise</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Periodic/PRN</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Immunization

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Flu</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pneumovax</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tetanus</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Discussion:**  
Living Will: □ Yes □ No  
Donor Card: □ Yes □ No  
(continued)
Adult Health Maintenance Record Continued

Name: _________________________________________  Date of Birth: ______________________

Allergies to Medications, X-Ray Dyes, or Other Substances  □ No  □ Yes

PROBLEM LIST

<table>
<thead>
<tr>
<th>Chronic Problem(s)</th>
<th>Date(s)</th>
<th>Hospitalizations/Surgeries</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td>2.</td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td>3.</td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td>4.</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>5.</td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td>6.</td>
</tr>
</tbody>
</table>

Acute Problems      Date(s)

<table>
<thead>
<tr>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICATIONS

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Date Begin</th>
<th>Date D/C’d</th>
<th>Drug</th>
<th>Dose</th>
<th>Date Begin</th>
<th>Date D/C’d</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### AGES BIRTH - 2 YEARS COMPREHENSIVE EXAM

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name &amp; Address</th>
<th>Age</th>
<th>Wt. (Kgs/lbs)</th>
<th>Ht.</th>
<th>B/P</th>
<th>Temp.</th>
</tr>
</thead>
</table>

#### Allergies
- **NKA**

#### Current Medication

#### Reason for Visit
- PMH/Illness

#### History

<table>
<thead>
<tr>
<th>Age</th>
<th>Activity</th>
<th>Age</th>
<th>Activity</th>
<th>Age</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Kick Ball</td>
<td>3</td>
<td>Jump</td>
<td>4</td>
<td>Climb Ladder</td>
</tr>
<tr>
<td>&amp;</td>
<td>4 Body Part</td>
<td>&amp;</td>
<td>Full Name/Name 4 Picture</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D</td>
<td>1, Me, You/2-Word Phrase</td>
<td>D</td>
<td>Can Button</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Skip on 1 Foot</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Safety
- Car Seat/Seat Belt
- Bike Safety/Helmet
- Home/Outdoor/Firearms
- Smoke Alarm/Smoker @ Home
- Caretaker CPR Training
- Ipecac Syrup
- Poison Control #

#### Dental Health/Flouride
- Diet/Exercise
- Elim./Voids
- Sleep

#### Immunization
- General Condition
- Head
- Eyes/Vision
- Ears/Hearing/TMS
- Nose
- Mouth/Throat
- Neck/Nodes
- Lungs
- Heart
- Abdomen
- Skin
- Genitalia/Tanner
- Ext./Back & Spine
- Neuromuscular
- Parent/Child Interaction

#### Assessment Plan

<table>
<thead>
<tr>
<th>F/U</th>
<th>Wks / Mos</th>
<th>Sig.</th>
<th>Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE/YEARS 4-6</td>
<td>VISION ** TYMPANOGRAM **</td>
<td>HEARING OTHER</td>
<td></td>
</tr>
<tr>
<td>OPV □</td>
<td>CBC/HEMOGRAM</td>
<td></td>
<td></td>
</tr>
<tr>
<td>DTP/DTaP □</td>
<td>U/A-URINE DIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR □</td>
<td>** LEAD LEVEL **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>*HEP. B □</td>
<td>** SICKLE CELL PREP **</td>
<td></td>
<td></td>
</tr>
<tr>
<td>* VZV □</td>
<td>CHOLESTEROL</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PPD □</td>
<td>** AT RISK</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*NOT GIVEN OR INDICATED*
## AGES 2 – 6 YEARS COMPREHENSIVE EXAM

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name &amp; Address</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### History

#### Age
- **2**  
  - Kick Ball
- **4**  
  - Body Part
- **1**, Me, You/2-Word Phrase
- **3**  
  - Jump
- **5**  
  - Skip on Both Feet
- **6**  
  - Climb Ladder

#### Allergies
- □ NKA

#### Current Medication
- PMH/Illness

#### Reason for Visit
- PMH/ Illness

#### Safety
- Car Seat/Seat Belt
- Bike Safety/Helmet
- Home/Outdoor/Firearms
- Smoke Alarm/Smoker @ Home
- Caretaker CPR Training
- Ipecac Syrup
- Poison Control 

### Physical Exam

#### General Condition
- Head
- Eyes/Vision
- Ears/Hearing/TMS
- Nose
- Mouth/Throat
- Neck/Nodes
- Lungs
- Heart
- Abdomen
- Skin
- Genitalia/Tanner
- Ext./Back & Spine
- Neuromuscular
- Parent/Child Interaction

### Assessment Plan

#### F/U
- Wks / Mos

### Immunization

#### Age/Years
- 4-6

<table>
<thead>
<tr>
<th>OPV</th>
<th>DTP/DTaP</th>
<th>MMR</th>
<th>*HEP. B</th>
<th>*VZV</th>
<th>PPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
<td>□</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>VISION</th>
<th>** TYPANOMGRAM</th>
<th>HEARING</th>
<th>OTHER</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>CBC/HEMOGRAM</td>
<td>U/A-URINE DIP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>** LEAD LEVEL</td>
<td>** SICKLE CELL PREP</td>
<td></td>
</tr>
<tr>
<td></td>
<td>CHOLESTEROL</td>
<td>** AT RISK</td>
<td></td>
</tr>
</tbody>
</table>

*NOT GIVEN OR INDICATED
# AGES 7 – 12 YEARS COMPREHENSIVE EXAM

<table>
<thead>
<tr>
<th>Date</th>
<th>Patient Name &amp; Address</th>
</tr>
</thead>
</table>

|-----|-----|---------|-----|-----|-------|

| Allergies | □ NKA | Current Medication |

<table>
<thead>
<tr>
<th>Reason for Visit</th>
<th>PMH/Illness</th>
</tr>
</thead>
</table>

## History

<table>
<thead>
<tr>
<th>Age</th>
<th>7 Years &amp; Up</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Grade</th>
<th>Performance</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Safety</th>
<th>Lap/Shoulder Belt</th>
<th>Bike Helmets</th>
<th>Home/Outdoor/Firearms</th>
<th>Smoke</th>
<th>Substance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dental Health</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Diet/Exercise</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Elim./Voids</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Sleep</th>
</tr>
</thead>
</table>

## Physical Exam

<table>
<thead>
<tr>
<th>Immunization</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>General Condition</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Head</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Eyes/Vision</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ears/Hearing/TMS</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Nose</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mouth/Throat</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Neck/Nodes</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Lungs</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Heart</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Abdomen</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Genitalia/Tanner</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Ext./Back &amp; Spine</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Neuromuscular</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Parent/Child Interaction</th>
</tr>
</thead>
</table>

## Assessment Plan

<table>
<thead>
<tr>
<th>F/U</th>
<th>Wks / Mos</th>
<th>Sig.</th>
<th>Title</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>AGE/YEARS</th>
<th>4-6</th>
<th>11-12</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>OPV</th>
<th></th>
<th>to</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DTP/DTaP</th>
<th>2</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>MMR</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>*HEP, B</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>* VZV</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>PPD</th>
<th></th>
</tr>
</thead>
</table>

| * NOT GIVEN OR INDICATED | |

<table>
<thead>
<tr>
<th>VISION</th>
<th>** TYMPANOGRAM</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>HEARING</th>
<th>OTHER</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CBC/HEMOGRAm</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>U/A-URINE DIP</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>** LEAD LEVEL</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>** SICKLE CELL PREP</th>
<th></th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>CHOLESTEROL</th>
<th></th>
</tr>
</thead>
</table>

| ** AT RISK | |

Anthem Blue Cross and Blue Shield
Change in Office Form

The information you provide on this form will enable us to establish accurate records that will help to promote rapid claims processing. Please fax this form to (203) 654-3216.

Physician/Health Care Provider Name: _________________________________

Effective Date of Change: ___________________________________________

• Changing Your Address

FROM:
Group Name (if applicable): __________________________________________
Street Address                       City, State        Zip Code

TO:
Group Name (if applicable): __________________________________________
Address: __________________________________________________________
Street Address                       City, State        Zip Code

• Is Your Tax Identification Number Changing? (Check One)

☐ No    ☐ Yes    New Tax Identification Number: ________________________
☐ Social Security Number      ☐ Federal Tax Identification Number

• Is Your Phone Number OR Contact Person Changing? (Check One)

☐ No    ☐ Yes    New Contact Person and Number: ________________________

• Opening an Additional Office

Group Name (if applicable): __________________________________________
Address: __________________________________________________________
Street Address                       City, State        Zip Code

Tax Identification Number: __________________________________________
☐ Social Security Number      ☐ Federal Tax Identification Number

Contact Person and Phone Number: ____________________________________
• **Closing an Office**

  Group Name (if applicable): __________________________________________

  Address: ____________________________________________________________

  Contact Person and Phone Number: ____________________________________

• **Miscellaneous Changes**

  □ Change in the status of my **hospital admitting privileges**. (Please explain below.)

    ________________________________________________________________

  □ Change in the status of my **medical licensure or certification**. (Please explain below.)

    ________________________________________________________________

  □ Change in the status of my **malpractice insurance**. (Please explain below.)

    ________________________________________________________________

• **Changing Physician/Health Care Provider Associates**

  □ New Provider in Your Group       □ Provider Has Left Your Practice

  □ Miscellaneous (please explain) ______________________________________

  Name of Associate: ___________________________________________________

  Group Name (if applicable): ___________________________________________

  Address: ____________________________________________________________

  Tax Identification Number: ____________________________________________

    □ Social Security Number       □ Federal Tax Identification Number

  Effective Date of Change: ____________________________________________
Covering Physician Agreement

____________________________
(Date)

____________________________
____________________________
____________________________

Dear ______________________:

I have notified Anthem Blue Cross and Blue Shield that you are a physician who routinely
cross-covers my practice.

As such, you agree to provide care and services to my patients in cases of emergency and at
other times when the services of a covering physician are required.

Some of my patients may be covered under a health benefits program that is a product of
Anthem Blue Cross and Blue Shield including BlueCare Health Plan. As a participating provider
with Anthem, I have agreed that I will accept compensation for services rendered to their members in
accordance with my agreement with Anthem. In addition, I have agreed to comply with the
requirements of the various programs that I participate in, such as authorizations, referrals, policies
and procedures, etc. One of the essential provisions of my agreement requires me to agree that I will
not balance bill members for the difference between the contract compensation and my billed charges.

It is a condition of my agreement with Anthem that if I make cover arrangements with a non-
participating physician, I must secure that physician’s agreement to abide by the same rules that I
have agreed to abide by when rendering care to members of Anthem. Your signature below reflects
your agreement in that regard.

Anthem will, most likely, be contacting you shortly to obtain information that will enable them
to process payments directly to you as my covering physician.

Thank you, once again, for agreeing to cover for me.

Sincerely,

__________________________________
(Print Name)

I have read the above and I agree to the stated requirements in the circumstances described.

__________________________________  _______________
(Signature of Covering Physician)        (Date)
Locum Tenens Credentialing Questionnaire

INSTRUCTIONS

☐ Please type or print legibly.

☐ Include Curriculum Vitae (CV).

☐ Make sure to sign and date the Certification and Release.

☐ If you have any questions, please call the Provider Call Center at
  (800) 922-3242 (toll free in Conn.), or (203) 239-3884 (local North Haven).

☐ Return the completed form to the address listed below:

Professional Credentialing Department
Anthem Blue Cross and Blue Shield
Post Office Box 1090
370 Bassett Road
North Haven, CT 06473-1090
**Locum Tenens**

**PHYSICIAN CREDENTIALING QUESTIONNAIRE**

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Sr.</th>
<th>Jr.</th>
<th>II</th>
<th>III</th>
<th>IV</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Social Security Number</th>
<th>UPIN Number</th>
<th>Gender</th>
</tr>
</thead>
<tbody>
<tr>
<td>/ /</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Office Manager or Contact Person

**Dates of Office Coverage**

From: __________ To: __________

<table>
<thead>
<tr>
<th>Office Information</th>
<th>Primary Office Location</th>
<th>Other Office Location</th>
<th>Other Office Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Street Address</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Town, State, Zip</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Phone Number</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fax Number</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Group, Partnership or Corporation Name</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Participating Physician</th>
<th>Federal Tax ID Number</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Type of Practice</th>
<th>Solo</th>
<th>Group</th>
<th>Other/Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**LICENSURE**

<table>
<thead>
<tr>
<th>State(s) in Which Licensed</th>
<th>License Number</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Federal Controlled Substance Registration (DEA) Number(s)</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>State Controlled Substance Registration Number(s)</th>
<th>Expiration Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CURRENT HOSPITAL PRIVILEGES

<table>
<thead>
<tr>
<th>Hospital</th>
<th>Type of Privileges (e.g. Unrestricted, Courtesy)</th>
<th>Location</th>
<th>Percent of Your Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MALPRACTICE “COVERAGE”

<table>
<thead>
<tr>
<th>Malpractice Carrier</th>
<th>Coverage Limits (Per Occurrence/Annual Aggregate)</th>
<th>Policy Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

OTHER INFORMATION

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has your malpractice insurance ever been canceled, non-renewed, or special rated?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have any judgments or settlements been made on your behalf for alleged malpractice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there any pending actions against you for alleged malpractice?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your board certification ever been suspended, revoked, or voluntarily surrendered or suspended?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your membership in a professional society, college association, or academy ever been suspended, revoked, or voluntarily surrendered or suspended?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your professional training, experience, or practice ever been interrupted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your license to practice medicine in any jurisdiction ever been suspended or revoked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Has your narcotics license ever been suspended, revoked, or voluntarily surrendered or has probation been revoked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have your privileges at any hospital or other facility ever been suspended, denied, restricted or revoked?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been indicated in a criminal action?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have you ever been the subject of an investigation by Medicare or Medicaid authorities?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do you have any on going physical or mental impairment which would make you unable, with or without reasonable accommodation, to perform the essential functions without a direct threat to the health and safety of others?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Considering the essential function of a physician in your area of practice, are you suffering from any communicable health condition that could pose a significant health and safety risk to your patients?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

For each question (1 through 13) to which you answered “Yes”, please attach an explanation on an additional sheet of paper that includes applicable dates, action taken and other pertinent information. Please sign and date your explanation.
Certification and Release

I hereby affirm and represent that all statements and information contained in this questionnaire are true to the best of my knowledge and belief. I agree to inform Anthem Blue Cross and Blue Shield or its affiliates (Blue Cross & Blue Shield) promptly of any change in the information provided in this questionnaire. I understand that false or misleading information or the withholding of information deemed relevant by Anthem Blue Cross and Blue Shield will disqualify me from consideration as a locum tenen for an Anthem Blue Cross and Blue Shield participating physician.

In consideration of Anthem Blue Cross and Blue Shield’s processing of this questionnaire:

I hereby authorize Anthem Blue Cross and Blue Shield, its agents and employees to request and obtain information deemed relevant to my credentials and qualifications from any hospital, insurance carrier, medical school, medical association or society, organization or entity or other person. This information may include but is not limited to disciplinary action, termination, suspension or curtailment of medical-surgical privileges, or action by a hospital, government agency or any other organization pertaining to my conduct of medical practice, even if otherwise privileged or confidential.

I hereby authorize any hospital, insurance carrier, medical school association or society, organization or entity, or other person, to consult with and to provide and make available to Anthem Blue Cross and Blue Shield, its agents and employees, information and records that may be requested by Anthem Blue Cross and Blue Shield. This information may include but is not limited to disciplinary action, termination, suspension or curtailment of medical surgical privileges, or action by a hospital, government agency or any other organization pertaining to my conduct of medical practice, even if otherwise privileged or confidential.

I further understand that my completion and submission of this questionnaire only entitles me to be considered as a candidate to become a substitute physician for Anthem Blue Cross and Blue Shield participating physician. I understand that any decision with respect to my becoming such a substitute physician for Anthem Blue Cross and Blue Shield participating physician remains the sole discretion of Anthem Blue Cross and Blue Shield.

This release is granted with the understanding that Anthem Blue Cross and Blue Shield will take responsible measures to maintain the confidentiality of this information.

I release and waive all claims related to the good faith furnishing or review of the information described above.

_____________________________________________  ___________________
Sign       Date

_____________________________________________
Type or print name of signatory
Required letter from Participating Physician to Locum Tenen

Please submit a copy of this letter, signed by both the physician and Locum Tenen to the Provider Relations Department along with the Locum Tenen Physician Credentialing Questionnaire.

____________________
Date
___________________________
___________________________
___________________________

Dear_______________:

I have notified Anthem Blue Cross and Blue Shield that you are a physician who will be a substitute physician for my practice from ____________________ to ____________________.

Date     Date

As such, you agree to provide care and services to my patients in cases of emergency and at other times when the services of a covering physician are required.

Some of my patients may be covered under a health benefits program offered by Anthem. As a participating provider with Anthem, I have agreed that I will accept compensation for services rendered to their members in accordance with my agreement with Anthem. In addition, I have agreed to comply with the requirements of various programs that I participate in, such as prior authorization, referrals, and all other policies and procedures. One of the essential provisions of my agreement requires me to agree that I will not balance bill members for the difference between the contract compensation and my billed charges.

It is a condition of my agreement with Anthem that if I make substitute arrangements with a non-participating physician, I must secure that physician’s agreement to abide by the same rules that I have agreed to abide by when rendering care to a Anthem member. Your signature below reflects your agreement in that regard.

Thank you, once again, for agreeing to substitute for me.

Sincerely,

______________________________  ______________________________
Signature of Physician   Print Name

I have read the above and agree to the stated requirements in the circumstances described.

______________________________  ______________________________
Signature of Locum Tenen     Date
Medical Surgical Provider Refund Form

Medical /Surgical Provider Refund

Date: __________________

To:     Anthem Blue Cross and Blue Shield
        P.O. Box 1091
        North Haven, CT  06473-5191

ATT:  Provider Call Center

Provider’s Name and Address

Please check either of the following boxes:

[ ]  Please deduct this overpayment from future remittances

[ ]  I have attached my personal check for this overpayment.

Anthem Blue Cross and Blue Shield Provider Number ____________________

The following information must be completed for each refund. A receipt will be mailed to you to acknowledge your refund only when you are refunding your personal check.

•  Patient’s Name _____________________________________
•  Anthem Identification Number ________________________
•  Claim Number ______________________________________
•  Date (s) of Service __________________________________
•  Procedure/Service ___________________________________
•  Total Charge _______________________________________
•  Anthem Payment Amount _____________________________
•  Anthem Payment Date ________________________________
•  Your Refund Check Number ___________________________

REASON FOR REFUND (Check One)

[ ]  Not out Patient
[ ]  Charges billed in error
[ ]  Worker’s Comp. Liability
[ ]  Paid by Other Insurance *
[ ]  Paid by Third Party Liability

[ ]  Other (Explain Below)

*Please indicate Name and Address of Other Insurance Company

____________________________________________________________________

____________________________________________________________________

Your Name

____________________________________________________________________

Your Office Telephone Number

Anthem Blue Cross and Blue Shield
PATIENT INFORMATION FORM

PATIENT: (THIS SECTION REFERS TO PATIENT ONLY)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Sex:</th>
<th>Marital Status:</th>
<th>Birth Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>☐ S ☐ M ☐ D ☐ W</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Address:</th>
<th>SS#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City</th>
<th>State:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Home Phone: ( )</th>
<th>Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Work Phone: ( )</th>
<th>City:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Spouse’s Name:</th>
<th>Spouse’s Employer:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Emergency Contact:</th>
<th>Relationship: Phone #:</th>
</tr>
</thead>
</table>

FILL IN IF PATIENT IS A MINOR

<table>
<thead>
<tr>
<th>Fathers Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Mother’s Name:</th>
<th>Date of Birth:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Employer’s Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer:</th>
<th>Employer’s Phone:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Employer Address:</th>
<th>Employer Address:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City:</th>
<th>State:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>SS#:</th>
<th>City:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Zip:</th>
<th>SS#:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>School:</th>
<th>Guardian’s Name:</th>
</tr>
</thead>
</table>

INSURANCE

<table>
<thead>
<tr>
<th>Primary Insurance Co.:</th>
<th>Secondary Insurance:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Subscriber’s Name:</th>
<th>Subscriber’s Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Plan:</th>
<th>Plan:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Policy #:</th>
<th>Group #:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Copay:</th>
<th>Copay:</th>
</tr>
</thead>
</table>

OTHER INFORMATION

<table>
<thead>
<tr>
<th>Allergy to Medication:</th>
<th>☐ No ☐ Yes If yes, list:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Current Medications:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Significant Medical History (Illness/Surgeries):</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>If referred by M.D.:</th>
<th>Name:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Primary Care Physician:</th>
<th>Name:</th>
</tr>
</thead>
</table>

RELEASE OF INFORMATION

I authorize my physician, health care provider, and their representatives to release any information relating to an illness, injury, diagnosis, care or treatment to my insurance company, health plan, Medicare, Medicaid, or third party payor or their agents, contractors, subcontractors or affiliates provided they agree such information is kept confidential. Such information shall include, but is not limited to any medical records and medical information, including: psychiatric, psychological, nervous/mental, substance abuse (e.g. alcohol and drug abuse) and HIV and HIV-related information. I understand that the reason for furnishing such information may include the following: for use in medical, financial or provider auditing, or such other auditing as may be legally required, for utilization and/or quality of care review and assessment and for determining available health benefits and coverage.

______________________________________________  ________________
(Patient’s signature/Parent’s signature)        (Date)
## PROVIDER FEEDBACK SURVEY
### CLINICAL MEDICAL RECORD REVIEW

<table>
<thead>
<tr>
<th></th>
<th><strong>YES</strong></th>
<th><strong>NO</strong></th>
<th><strong>N/A</strong></th>
<th><strong>COMMENTS</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Did our communications efforts before the visit explain to you and/or your staff the purpose of the visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Were our Medical Record Review standards familiar to you prior to our initial contact letter?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Was the purpose of the review clear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Did you find the reviewer to be helpful and professional on the telephone and/or at the office?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Was the visit informative and convenient in terms of:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scheduling……</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Length of Time…</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Feedback………..</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Do you feel our Clinical Medical Record Review standards are appropriate and/or clear?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Were specific review issues clearly addressed in the reviewer’s feedback?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Does our feedback compare favorably to other review processes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Was the nurse reviewer helpful in resolving any issues/problems you or your staff brought to his/her attention?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Will you incorporate any of our suggestions into your practices or office procedures, if applicable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11.</td>
<td>Is the information you receive (i.e. newsletters, bulletins, flowsheets, forms, etc.) helpful?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12.</td>
<td>Would you mention this program favorably to your peers?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

____________________________________   _______________________________
**SIGNATURE**       **TITLE**

*** Thank you for your response ***
BlueCare Health Plan

Member Self-Referral Acknowledgment

I, ________________________________, understand that I am seeking the care of this specialty physician or health care provider, ________________________________, without a referral from my primary care physician. I understand that the terms of my BlueCare Health Plan coverage require that I obtain that referral, and that if I fail to do so, BlueCare Health Plan will not cover any part of the charges, costs or expenses related to this specialist’s services to me.

Signed,

___________________________________  ___________
(member’s name)     (date)

*************************************************
Specialty physician or other health care provider:

Please keep a copy of this form in your patient’s file
## 21. GLOSSARY

<table>
<thead>
<tr>
<th>Access</th>
<th>A patient’s ability to access medical care. The ease of access is determined by components such as availability of medical services and their acceptability to the patient, location of health care facilities, providers, transportation time and hours of operation.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accidental Ingestion or Consumption of a Controlled Drug</td>
<td>The swallowing by accident or mistake of a controlled drug, defined as (1) a drug which contains any quantity of a substance that has been designated as subject to the Federal Controlled Substances Act; (2) a drug designated as a depressant, stimulant or hallucinogenic drug pursuant to any other federal or state law or by an applicable agency.</td>
</tr>
<tr>
<td>Accreditation</td>
<td>The process by which an independent agency or organization evaluates and recognizes a health care facility, provider, health plan or program for purposes of assuring the public of its quality. One such agency is the National Committee for Quality Assurance (NCQA), which evaluates managed care plans. <em>(See also: NCQA, credentialing)</em></td>
</tr>
<tr>
<td>Acute Care</td>
<td>A level of care that can only be rendered in a hospital.</td>
</tr>
<tr>
<td>Ambulance Service</td>
<td>A commercial or municipal ambulance service licensed or certified by the State of Connecticut Office of Emergency Medical Services. If out-of-state, the service must have an equivalent licensure.</td>
</tr>
<tr>
<td>Ambulatory Care</td>
<td>Medical services provided on an outpatient basis.</td>
</tr>
<tr>
<td>Ambulatory Surgical Facility</td>
<td>A facility licensed by the State of Connecticut to perform surgical procedures on an outpatient basis. If out-of-state, the facility must have an equivalent license.</td>
</tr>
<tr>
<td>Appropriate Care</td>
<td>Medical care provided for a diagnosis that, in terms of medical necessity, setting, types of treatment, duration or length of stay and frequency, is based on a generally accepted medical treatment.</td>
</tr>
<tr>
<td>Benefit Period</td>
<td>The number of days or units of service for which a health plan will extend benefits during a specified length of time, such as two office visits a year.</td>
</tr>
<tr>
<td>Birthday Rule</td>
<td>The guideline that determines which of two parents’ health insurance plans is primary for dependent children. Generally, under the birthday rule, the parent whose birthday comes first during the year is considered to have the primary insurance plan for the children. Any balance may be submitted to the other spouse’s plan for additional consideration <em>(See also: Coordination of Benefits)</em></td>
</tr>
<tr>
<td>Calendar Year</td>
<td>Jan. 1 through Dec. 31 of the same year. When the member first enrolls, their calendar year begins on their effective date and ends on Dec. 31 of the same year.</td>
</tr>
<tr>
<td>Term</td>
<td>Definition</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Capitation</td>
<td>A method of payment for health services in which an individual or institutional provider is paid a fixed amount for each person served without regard to the actual number or nature of services provided to each person. Capitation is a common compensation method used by many health maintenance organizations.</td>
</tr>
</tbody>
</table>
| “Carve-outs” - Non-standard coverage | Employer groups covered by any of our products or programs may opt to “carve-out” specific portions of that coverage. Under these circumstances, the following could occur:  
  • Specific benefit(s) may not be covered that are covered under the standard plan.  
  • A specific area of coverage (such as behavioral health) may be provided by a network of providers other than the standard plan network (an example would be ValueOptions taking the place of behavioral health providers in an Anthem network such as the BlueCare Health Plan or Century Preferred). |
| Case Management                     | A review of a member’s special medical needs and implementation of benefits to match an appropriate treatment plan to help the member reach an optimum level of wellness.                                          |
| Case Manager                        | A professional (e.g., nurse, doctor or social worker) who works with patients, providers and insurers to coordinate all services deemed medically necessary for the patient.                                             |
| Clinical Transition Program         | A program designed to aid the member who is transitioning into an Anthem health plan from another health plan. A nurse consultant will facilitate ongoing care, and transition the care into the member’s new provider network and benefit design. |
| COBRA                               | The common acronym for the Consolidated Omnibus Budget Reconciliation Act of 1986. The impact of this federal law is to allow individuals, in certain cases, to continue for a specified period, their group health insurance coverage after termination of their employment. |
| Coinsurance                         | The percentage of health care expenses that a member is responsible for paying. For example, if a policy covers 80 percent of a given expense, the member’s responsibility, or coinsurance amount, is 20 percent. |
| Coordination of Benefits            | Also known as COB, this is a stipulation in most health insurance policies that helps prevent double payments for services covered by more than one policy or program. For example, a person may be covered by his or her own policy, as well as a spouse’s. Eligible medical expenses are covered first by a person’s own policy. Any balance is submitted to the spouse’s health plan for additional consideration (See also: Birthday Rule) |
| Concurrent Review                   | An ongoing evaluation of the continued eligibility for coverage of a member’s hospital stay and treatment. The process involves the hospital utilization review department, the physician, the patient and the consulting physician reviewers. |
| Copay                               | A fixed amount a member pays for each covered service or prescription at the time the service is rendered or the prescription is dispensed; for example, a $15 copay per office visit or a $5 copay per prescription. |
| Cost Sharing                        | A general term used for out-of-pocket expenses (deductibles, copays and/or coinsurance) paid by a health plan member. (See also: Coinsurance, Copay, Deductible) |
| Covered Service | Diagnosis, care, treatment or supplies that;  
| a. | Are medically necessary  
| b. | Are not described as exclusions or limitations under the member’s Subscriber Agreement. |
| Credentialing | A process of review to approve a provider who applies to participate in a health plan. Specific criteria may include appropriate medical education and training, board certification, adequate office hours and appropriate treatment patterns. |
| Deductible | The amount a member must pay out-of-pocket before an insurance policy begins to pay benefits. Deductibles usually are fixed-dollar amounts based on a specific benefit period (such as $200 per year.) |
| Durable Medical Equipment | Commonly referred to as DME, it is equipment that can stand repeated use and is primarily and customarily used for medical purposes, generally is not useful in the absence of illness or injury, and is appropriate for use at home. Examples include hospital beds, wheelchairs and oxygen equipment. |
| Elective Surgery | A procedure that does not have to be performed on an emergency basis, but can be reasonably delayed. Such surgery may still be considered medically necessary, however. |
| Emergency Medical Care | The term Medical Emergency means the onset of a serious illness or injury which requires emergency medical treatment; or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is needed. |
| Experimental or Investigational | The term experimental or investigational means services or supplies which include, but are not limited to, any diagnosis, treatment, procedure, facility, equipment, drugs, drug usage, devices or supplies which are determined in the sole discretion of consultants designated by Anthem to be experimental or investigational.  
In making its determination, Anthem will deem a service or supply to be experimental or investigational if it satisfies one or more of the following criteria:  
1. The service or supply does not have final approval by the appropriate government regulatory body or bodies, or such approval for marketing has not been given at the time the service or supply is furnished, or  
2. A written informed consent form for the specific service or supply being studied has been reviewed and/or has been approved or is required by the treating facility’s Institutional Review Board, or other body serving a similar function or if federal law requires such review and approval; or  
3. The service or supply is the subject of a protocol, protocols or clinical trial study, or is otherwise under study in determining its maximum tolerated toxicity dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis. (continued)  
Notwithstanding the above, services or supplies will not be considered experimental if they have completed a Phase III clinical trial of the federal Food and Drug Administration for the illness or condition being treated, or the diagnosis for which it is being prescribed.  
In addition, a service or supply may be deemed Experimental or Investigational based upon:  
1. Published reports and articles in the authoritative medical, scientific and peer review literature; or  

2. The written protocol or protocols used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

**Explanation of Benefits**

Also known as EOB, this is a printed form sent by an insurance company to a member after a claim has been filed and adjudicated. The EOB includes such information as the date of service, name of provider, amount covered and patient balance. An Explanation of Medicare Benefits, or EOMB, is similar, except it is sent following submission of a Medicare claim.

**Fee-for-Service**

The traditional health care payment system under which physicians and other health care professionals bill and receive payment for each encounter or service rendered.

**Fee Schedule**

A list of codes and related services with pre-established payment amounts that may be represented as percentages of billed charges, a flat rate or a maximum allowable charge.

**Gatekeeper**

(See Primary Care Physician)

**Generic Drug**

The chemically equivalent version of a brand-name drug who’s patent has expired. Though they have the same therapeutic value as brand-name drugs, generics typically are considerably less expensive.

**HEDIS**

The acronym for Health Plan Employer Data and Information Set. HEDIS is a core set of performance measures to assist employers and other health care purchasers in understanding the value of health care purchases and evaluating health plan performance.

**HMO**

The acronym for “health maintenance organization”, an organized system of health care that uses a designated network of physicians and other health care professionals to provide comprehensive medical services to its membership for a fixed, prepaid fee.

**HMO NEW ENGLAND**

A regional managed care initiative formed by Blue Cross & Blue Shield plans in New England. It is designed to meet the needs of employers with operations and employees in more than one New England state.

**Home Health Care**

An umbrella name of skilled nursing, occupational therapy and other health-related services provided at home by an accredited agency.

**Hospice**

A facility or program that provides care and support for terminally ill patients and their families.

**Indemnity**

A traditional insurance program in which the insured person is reimbursed by the health plan for covered expenses.

**Inpatient**

An individual who occupies a hospital bed - usually overnight- while receiving hospital care, including room, board and general nursing care.

**Long-term Care**

A broad range of services that addresses the ongoing health, personal and social needs of individuals who have lost some capacity for self-care. These services may include nursing home care, home health care and adult day care.
| Managed Benefits | An Anthem program that enables members to use their benefits most effectively. The Managed Benefits program is designed to educate members about benefit options and encourage them to actively participate in the management of their health care needs.

Components of the Managed Benefits program are:

- **Prior authorization of Hospital Admission**: Prior authorization of elective and maternity admissions up to one business day prior to hospital admission.
- **Emergency or Urgent Admission Review**: Review and authorization of all emergency and urgent admissions up to 48 hours or two business days following a hospital admission.
- **Concurrent Stay Review**: Assessment of medical necessity or appropriateness of services as they are being rendered.
- **Nurse Consultant Assistance**: Guidance of a registered nurse who is reached through a toll-free number to help members through the review process.
- **Case Management**: Comprehensive approach for dealing with costly, catastrophic or complex cases. Needs are identified and a plan of care is initiated to achieve optimum patient outcomes.
- **Behavioral Health Management**: Review and authorization for all inpatient mental health and substance abuse admissions. |

| Managed Care | The blanket term for products that integrate financing and delivery of health care services. This may be accomplished through:
- Arrangements with selected providers to furnish a comprehensive set of health care services to members.
- Explicit criteria for the selection of health care professionals.
- Formal programs for ongoing quality assurance and utilization review.
- Significant financial incentives for members to use physicians and services associated with the plan. |

| Mandated Benefits | Coverage for certain services as required by state and/or federal law to be included in health insurance contracts. |

| Medicaid | A federally-funded, state-administered medical assistance program for low-income people of any age. Eligibility varies from state to state. |

| Medical Emergency | The onset of a serious illness or injury which requires emergency medical treatment; or the onset of symptoms of sufficient severity that a member reasonably believes that emergency medical treatment is necessary. |

| Medicare | A federally-funded health insurance program that provides benefits for people age 65 and older. Some individuals under age 65 who are disabled or who have terminal kidney disease are also eligible for Medicare benefits. |

| Medigap | The common term for any one of the Medicare supplemental policies that can be purchased from private insurers. Such supplemental policies are designed to provide for some of the benefits not covered by Medicare. |
| **Medically Necessary Care** | Services, supplies or treatments rendered by a physician, provider or hospital that are judged by Anthem to be:  
- appropriate for, and consistent with, the symptoms and proper diagnosis or treatment of the condition, illness, disease or injury;  
- provided for, and consistent with, the proper diagnosis, or the direct care and treatment of the condition, illness, disease or injury;  
- in accordance with all applicable professional and legal standards;  
- the most appropriate supply or level of service that can safely be provided and which cannot be omitted under the professional standards referenced above. When applied to hospitalization this also means that the person requires acute care as a bed patient due to the nature of the services or the condition, and that the person cannot receive safe or adequate care as an outpatient;  
- Not Experimental or Investigational;  
- not primarily for the convenience of the member, the member’s family or the physician, provider or hospital; and  
- not a part of or associated with the scholastic education or vocational training of the patient. |
| **Medical Record Review** | A review used by Anthem in the recredentialing process. Providers’ medical records are reviewed in order to measure individual performance against established standards, to reinforce good performance, and to identify physicians whose performance varies significantly from their peers. |
| **NCQA** | The acronym for National Committee for Quality Assurance, a nationally recognized organization that evaluates managed care plans to help purchasers, regulators and consumers assess how well a plan serves its members. NCQA evaluates health plans in six areas: continuous quality improvement, credentialing, members’ rights and responsibilities, preventive health services, utilization management and medical records. |
| **Outcome Studies** | Studies that measure the effect of a treatment on a disease, disorder or physiological process using population-based data by quality-of-life and functional status assessment. Outcome studies are aimed at systematically improving health care results by modifying practices via a continuous quality improvement process. |
| **Out-of-Network** | The term for treatment or services rendered by a non-participating provider, usually at a higher out-of-pocket cost to the member than services rendered by a participating provider. |
| **Out-of-Pocket Maximum** | The total amount (deductible plus coinsurance) that a member will have to pay for medical expenses under his or her policy during a specified period. This is sometimes also known as the “cost share maximum”. |
| **Outpatient** | An individual whose medical care does not require a hospital bed or overnight admission to the hospital. |
| **Participating Provider** | Any appropriately licensed or certified health care physician, professional or facility designated and accepted as a participating provider by Anthem to provide Covered Services to members under the terms of the Policy. |
| **Plan** | Any plan which provides benefits or services for hospital, medical/surgical or other health care diagnosis or treatment on a group basis. |
| **Point-of-Service Plan (POS)** | A health plan that allows members to receive services from either participating or non-participating providers, but with a higher level of cost sharing associated with non-participating providers. *BlueCare Plus POS* is an example of a point-of-service plan. |
| **Practice Guidelines** | Generally accepted clinical principles or standards of care that assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. The Practice Guidelines developed by Anthem standardize care for acute, chronic and preventive conditions in an attempt to determine the most cost-effective and clinically effective treatments. |
| **Preferred Provider Organization (PPO)** | A group of health care professionals who contract with an insurer or employer to furnish services and accept compensation that is usually lower than their usual fees, in exchange for prompt payment and a reliable volume of patients. Anthem Blue Cross and Blue Shield’s *Century Preferred* plan is an example of a PPO. |
| **Premium** | The amount paid to an insurance company for enrollment in an underwritten insurance plan. |
| **Preventive Care** | Comprehensive care that emphasizes prevention, early detection and early treatment of conditions through routine physical exams, immunizations and health education. |
| **Primary Care Physician (PCP)** | A physician, usually a pediatrician, internist or family practice doctor who delivers or coordinates all of a member’s medical care. As the member’s first contact, the PCP provides a range of health care services, including initial diagnosis and treatment, health supervision, management of chronic conditions, preventive care and referrals to specialists, when appropriate. |
| **Prior Authorization** | Prior approval of the physician’s or health care provider’s treatment plan for coverage, based on medical necessity *before* treatment or hospital admission. *(See also: Managed Benefits)* |
| **Referral** | The formal recommendation by a physician and/or health plan for a member to receive care from a specialist or a different physician or facility. |
| **Rehabilitation Center** | A facility which provides occupational, speech and physical therapy treatment and is accredited for the provision of such services by the commission on Accreditation for Rehabilitation Facilities. |
| **Retrospective Review** | Cases that are reviewed retrospectively, on an as-needed basis. |
| **Skilled Nursing Facility** | A facility that accepts patients who need rehabilitation and medical care that is of a lesser intensity than that received in a hospital. |
| **Urgent Care** | Care for individuals with an illness or injury which is not a medical emergency but requires immediate medical attention. |
| **Utilization Management** | A process of integrating review and case management of services in a cooperative effort with other parties, including patients, employers, physicians and other health care providers and payers. |
| **Well Newborn** | An infant who: 1. weights more than five pounds; or 2. in the opinion of the attending Physician, does not have any disease, illness, injury or congenital anomaly requiring immediate medical attention during the Hospital stay in which the birth occurred; or 3. is not born of a mother with metabolic, endocrine or other disorders which are known to cause problems in the care of the infant during the neonatal period. |
## APPENDIX

### Table of Contents

- Appendix A .......................................................................................................................................2
  - Member Bill of Rights and Responsibilities................................................................................2
- Appendix B .......................................................................................................................................2
  - Quality Commitments to Managed Care Members .................................................................3
- Appendix C .......................................................................................................................................4
  - Hospital and Surgical Facility Code Listing...........................................................................4
- Appendix D .......................................................................................................................................8
  - Place of Service Codes..............................................................................................................8
- Appendix E .......................................................................................................................................9
  - Claim Information Required For Compensation .....................................................................9
- Appendix F ......................................................................................................................................11
  - National Directory of Blue Cross & Blue Shield Plans ..........................................................11
Appendix A

Member Bill of Rights and Responsibilities

We are committed to:
- Recognizing and respecting you as a member.
- Encouraging your open discussions with your health care professionals and providers.
- Providing information to help you become an informed health care consumer.
- Providing access to health benefits and our network providers.
- Sharing our expectations of you as a member.

You have the right to:
- Receive covered services from your primary care provider in a timely manner.
- Participate with your health care professionals and providers in making decisions about your health care.
- Select a participating primary care physician if required by your health benefit plan, and change your selection at any time.
- Receive the benefits for which you have coverage.
- Be treated with respect and dignity.
- Privacy of your personal health information, consistent with state and federal laws, and our policies.
- Receive information about our organization and services, our network of health care professionals and providers, and your rights and responsibilities.
- Discuss with your physicians and providers appropriate or medically necessary care for your condition, regardless of cost or benefit coverage.
- Make recommendations regarding the organization’s members’ rights and responsibilities policies.
- Voice complaints or appeals about: Our organization, any benefit or coverage decisions we (or our designated administrators) make, your coverage, or care provided.
- For assistance at any time, contact the Connecticut Insurance Department:
  Phone: (800) 203-3447
  Write: State of Connecticut Insurance Department
  P.O. Box 816
  Hartford, CT 06142-0816

You have the responsibility to:
- Choose a primary care physician if required by your health benefit plan.
- Understand your health problems and participate, along with your health care professionals and providers in developing mutually agreed upon treatment goals to the degree possible.
- Provide, to the extent possible, information that we and/or your health care professionals and providers need.
- Follow the plans and instructions for care that you have agreed on with your health care professional and provider.
- Tell your health care professional and provider if you do not understand your treatment plan or what is expected of you.
- Refuse treatment and be informed by your health care professional and provider about the consequences of your refusal.
- Know how and when to access care in routine, urgent and emergency situations.
- Follow all health benefit plan guidelines, provisions, policies and procedures.
- Let our Customer Service Department know if you have any changes to your name, address, or family members covered under your policy.
- Provide us with accurate and complete information needed to administer your health benefit plan, including other health benefit coverage and other insurance benefits you may have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members.
Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.

Rev. (1/05)
Appendix B
Blue Cross and Blue Shield Plan’s
Quality Commitments to Managed Care Members

The goal of Blue Cross and Blue Shield Plans is to promote excellent health care for our members.

High quality care is the priority of Blue managed care plans, their participating physicians and other providers. Improving patient health is a fundamentally interactive process between the qualified physicians participating with Blue managed care plans and knowledgeable patients, informed through patient education and open communication between patients and physicians.

As a result, Blue Cross and Blue Shield Plans make the following commitments:

**Promoting Patient Choice**
- Treatment options are openly discussed between Blue managed care plan physicians and patients. Treatment decisions are based on the best available scientific information, clinical evidence, and the unique needs of the patient.
- Blue managed care plans offer choices of customized health plans that address our members’ medical, financial and geographic needs.

**Recognition of Physician Leadership**
- Blue managed care plans support the patient-physician relationship by championing consumer protections, fostering open communications, and promoting state-of-the-art quality oversight.
- Qualified and experienced participating physicians assume the leadership role in providing appropriate health care to patients. The physician’s scientific knowledge of health and medicine and sensitivity to individual patient needs are the foundation that guides appropriate patient care.
- Physician advocacy for patients is respected by Blue managed care plans.
- Blue managed care plans view medical ethics as the cornerstone of the successful physician-patient relationship.
- Quality improvement activities and medical policy are developed, monitored and refined by Blue managed care plan physician medical directors, in cooperation with participating physicians, and according to sound medical judgment.

**Respect for Patients**
- Patient satisfaction is a priority. Blue managed care plans foster satisfaction by meeting our members’ needs for quality, accessibility, affordability, flexibility, responsiveness, participation and advocacy in health care.
- Patients have a right to information about their health care and health plan. Open discussion of all information that is relevant to the patient’s health is a critical component of the Blue managed care plan physician-patient relationship.
- Proactive member education and disclosure of health plan practices allow patients to make educated decisions about their health care options. Blue managed care plans inform our members about how to use their benefits and take the guesswork out of obtaining health care.
- Blue managed care plans are committed to satisfying our members’ most important expectation: quality health care.
- Health care is personal and confidential. Patient information is handled by Blue managed care plans in the strictest confidence.
- Blue managed care plans provide all patients and physicians an accessible, fair and reasonable forum for lodging and resolving complaints, grievances and appeals.
- Blue managed care plans offer access to a full range of appropriate health care services from preventive care and primary care services to highly specialized treatment and follow-up care.
Appendix C

Hospital, Surgical and Skilled Nursing Facility Code Listings

When services were rendered in a location other than the member’s home or the physician or health care provider’s office, the Facility Code of the location should be indicated in Box 32 of CMS-1500 form or in the appropriate location when filing electronically.

### Acute General Hospitals

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bradley Memorial Hospital</td>
<td>036</td>
</tr>
<tr>
<td>Bridgeport Hospital</td>
<td>023</td>
</tr>
<tr>
<td>Bristol Hospital</td>
<td>002</td>
</tr>
<tr>
<td>Charlotte Hungerford Hospital</td>
<td>007</td>
</tr>
<tr>
<td>Connecticut Children’s Medical Center</td>
<td>025</td>
</tr>
<tr>
<td>Danbury Hospital</td>
<td>024</td>
</tr>
<tr>
<td>Day Kimball Hospital</td>
<td>003</td>
</tr>
<tr>
<td>Greenwich Hospital</td>
<td>027</td>
</tr>
<tr>
<td>Griffin Hospital</td>
<td>028</td>
</tr>
<tr>
<td>Hartford Hospital</td>
<td>005</td>
</tr>
<tr>
<td>Hospital of Saint Raphael</td>
<td>020</td>
</tr>
<tr>
<td>Johnson Memorial Hospital</td>
<td>029</td>
</tr>
<tr>
<td>Lawrence &amp; Memorial Hospital</td>
<td>008</td>
</tr>
<tr>
<td>Manchester Memorial Hospital</td>
<td>010</td>
</tr>
<tr>
<td>Middlesex Memorial Hospital</td>
<td>012</td>
</tr>
<tr>
<td>MidState Medical Center</td>
<td>011</td>
</tr>
<tr>
<td>Milford Hospital</td>
<td>013</td>
</tr>
<tr>
<td>New Britain General Hospital</td>
<td>015</td>
</tr>
<tr>
<td>New Milford Hospital</td>
<td>017</td>
</tr>
<tr>
<td>Norwalk Hospital</td>
<td>031</td>
</tr>
<tr>
<td>Rockville General Hospital</td>
<td>032</td>
</tr>
<tr>
<td>Sharon Hospital</td>
<td>033</td>
</tr>
<tr>
<td>St. Francis Hospital &amp; Medical Center</td>
<td>018</td>
</tr>
<tr>
<td>St. Mary's Hospital</td>
<td>019</td>
</tr>
<tr>
<td>St. Vincent's Medical Center</td>
<td>035</td>
</tr>
<tr>
<td>Stamford Hospital</td>
<td>034</td>
</tr>
<tr>
<td>UCONN Health Center/John Dempsey Hospital</td>
<td>026</td>
</tr>
<tr>
<td>Waterbury Hospital</td>
<td>021</td>
</tr>
<tr>
<td>William W. Backus Hospital</td>
<td>001</td>
</tr>
<tr>
<td>Windham Community Memorial Hospital</td>
<td>022</td>
</tr>
<tr>
<td>Yale New Haven Hospital</td>
<td>016</td>
</tr>
</tbody>
</table>

### Surgical Centers

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advanced Colon Care Inc.</td>
<td>65A</td>
</tr>
<tr>
<td>The Bloomfield Eye Surgery Center LLC</td>
<td>29A</td>
</tr>
<tr>
<td>Bridgeport Surgical Center</td>
<td>120</td>
</tr>
<tr>
<td>Coastal Digestive Care Center LLC</td>
<td>31A</td>
</tr>
<tr>
<td>Connecticut Eye Surgery Center</td>
<td>23A</td>
</tr>
<tr>
<td>Connecticut Foot Surgery Center</td>
<td>320</td>
</tr>
<tr>
<td>Connecticut GI Endoscopy Center</td>
<td>349</td>
</tr>
<tr>
<td>Connecticut Orthopedic Specialists PC</td>
<td>045</td>
</tr>
<tr>
<td>Connecticut Surgical Center</td>
<td>121</td>
</tr>
<tr>
<td>Constitution Eye Surgery Center East LLC</td>
<td>08A</td>
</tr>
<tr>
<td>Constitution Eye Surgery Center, LLC</td>
<td>041</td>
</tr>
<tr>
<td>Danbury Surgical Center</td>
<td>115</td>
</tr>
<tr>
<td>Diagnostic Endoscopy LLC</td>
<td>07A</td>
</tr>
<tr>
<td>Digestive Disease Associates</td>
<td>62A</td>
</tr>
<tr>
<td>Easter Connecticut Endoscopy Center LLC</td>
<td>351</td>
</tr>
<tr>
<td>Endoscopy Center of Connecticut, LLC</td>
<td>046</td>
</tr>
<tr>
<td>Endoscopy Center of Northwest Connecticut</td>
<td>22A</td>
</tr>
<tr>
<td>The Endoscopy Center of Fairfield</td>
<td>02C</td>
</tr>
<tr>
<td>Fairfield County Endoscopy Center</td>
<td>28A</td>
</tr>
</tbody>
</table>
### Surgical Centers Continued

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fairfield Surgical Center LLC</td>
<td>090</td>
</tr>
<tr>
<td>Hamden Surgery Center</td>
<td>038</td>
</tr>
<tr>
<td>The Hand Center of Western Connecticut</td>
<td>058</td>
</tr>
<tr>
<td>Hartford Surgical Center</td>
<td>039</td>
</tr>
<tr>
<td>HealthSouth Surgery Center of Norwalk</td>
<td>30A</td>
</tr>
<tr>
<td>Johnson Surgery Center</td>
<td>122</td>
</tr>
<tr>
<td>Laser and Vision Surgery Center LLC</td>
<td>352</td>
</tr>
<tr>
<td>Litchfield Hills Surgery Center LLS</td>
<td>11C</td>
</tr>
<tr>
<td>Middlesex Surgical Center</td>
<td>130</td>
</tr>
<tr>
<td>Naugatuck Valley Surgical Center</td>
<td>125</td>
</tr>
<tr>
<td>New Vision Cataract Center LLC</td>
<td>353</td>
</tr>
<tr>
<td>OptiCare Eye Health Centers, Inc.</td>
<td>239</td>
</tr>
<tr>
<td>Robbins Eye Center</td>
<td>049</td>
</tr>
<tr>
<td>Shoreline Surgical Center LLC</td>
<td>72A</td>
</tr>
<tr>
<td>Stamford Surgical Center</td>
<td>134</td>
</tr>
<tr>
<td>Surgical Center of CT LLC</td>
<td>50A</td>
</tr>
<tr>
<td>Temple Surgical Center</td>
<td>040</td>
</tr>
<tr>
<td>Women's Surgical Center</td>
<td>126</td>
</tr>
</tbody>
</table>

### Skilled Nursing Facilities

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abbott Terrace Health Center</td>
<td>879</td>
</tr>
<tr>
<td>Adams House Healthcare</td>
<td>743</td>
</tr>
<tr>
<td>Ashlar of Newtown, Inc.</td>
<td>867</td>
</tr>
<tr>
<td>Avery Heights</td>
<td>702</td>
</tr>
<tr>
<td>Avon Health Center</td>
<td>823</td>
</tr>
<tr>
<td>Bayview Health Care Center</td>
<td>898</td>
</tr>
<tr>
<td>Beacon Brook Health Center</td>
<td>193</td>
</tr>
<tr>
<td>Beechwood Manor</td>
<td>835</td>
</tr>
<tr>
<td>Bethel Health Care Center</td>
<td>217</td>
</tr>
<tr>
<td>Blair Manor</td>
<td>229</td>
</tr>
<tr>
<td>Bloomfield Health Care Center</td>
<td>745</td>
</tr>
<tr>
<td>Branford Hills Health Care Center</td>
<td>857</td>
</tr>
<tr>
<td>Brightview Nursing</td>
<td>186</td>
</tr>
<tr>
<td>Britanny Farms Health Center</td>
<td>824</td>
</tr>
<tr>
<td>Brook Hollow Health Care Center</td>
<td>748</td>
</tr>
<tr>
<td>Brookview Health Care Center</td>
<td>825</td>
</tr>
<tr>
<td>Cambridge Manor of Fairfield</td>
<td>897</td>
</tr>
<tr>
<td>Candlewood Valley Care Center</td>
<td>795</td>
</tr>
<tr>
<td>Carolton Chronic and Convalescent Hospital</td>
<td>750</td>
</tr>
<tr>
<td>Cedar Lane Rehabilitation Center</td>
<td>692</td>
</tr>
<tr>
<td>Chamberlain Health Care , Inc. NEW</td>
<td>305</td>
</tr>
<tr>
<td>Cherry Brook Health Care Center</td>
<td>196</td>
</tr>
<tr>
<td>Chestelm Health Care</td>
<td>179</td>
</tr>
<tr>
<td>Crestfield Rehabilitation Center (Subacute Care Only)</td>
<td>754</td>
</tr>
<tr>
<td>Crescent Manor</td>
<td>227</td>
</tr>
<tr>
<td>Douglas Manor (Health Care Assurance, LLC)</td>
<td>725</td>
</tr>
<tr>
<td>Ellis Manor</td>
<td>719</td>
</tr>
<tr>
<td>Evergreen Health Care Center</td>
<td>883</td>
</tr>
<tr>
<td>Fox Hill Nursing &amp; Rehab Center</td>
<td>790</td>
</tr>
<tr>
<td>Gaylord Hospital</td>
<td>077</td>
</tr>
<tr>
<td>Geer Nursing and Rehabilitation</td>
<td>710</td>
</tr>
<tr>
<td>Glastonbury Health Care Center</td>
<td>243</td>
</tr>
<tr>
<td>Glendale Nursing and Rehabilitation Center</td>
<td>763</td>
</tr>
<tr>
<td>Greentree Manor Nursing and Rehab Center</td>
<td>766</td>
</tr>
<tr>
<td>Greenwich Woods Health Care</td>
<td>889</td>
</tr>
<tr>
<td>Groton Regency Nursing and Rehab Center</td>
<td>732</td>
</tr>
<tr>
<td>Grove Manor Nursing Home (Subacute Care Only)</td>
<td>767</td>
</tr>
<tr>
<td>Hamden Health Care Center</td>
<td>855</td>
</tr>
<tr>
<td>Harbor Hill Care Center</td>
<td>263</td>
</tr>
<tr>
<td>Skilled Nursing Facilities continued</td>
<td></td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Harborside HealthCare – Arden House</td>
<td>742</td>
</tr>
<tr>
<td>Harborside HealthCare – Glen Hill (Subacute Care Only)</td>
<td>764</td>
</tr>
<tr>
<td>Harborside HealthCare – Governor’s House</td>
<td>286</td>
</tr>
<tr>
<td>Harborside HealthCare – Willows</td>
<td>277</td>
</tr>
<tr>
<td>Harborside HealthCare – Madison House</td>
<td>220</td>
</tr>
<tr>
<td>Harborside HealthCare – The Reservoir</td>
<td>240</td>
</tr>
<tr>
<td>Harrington Court</td>
<td>723</td>
</tr>
<tr>
<td>Haven Health Center of Cromwell</td>
<td>727</td>
</tr>
<tr>
<td>Haven Health Center of Danielson</td>
<td>794</td>
</tr>
<tr>
<td>Haven Health Center of East Hartford</td>
<td>792</td>
</tr>
<tr>
<td>Haven Health Center of Farmington</td>
<td>98A</td>
</tr>
<tr>
<td>Haven Health Center of Jewett City</td>
<td>836</td>
</tr>
<tr>
<td>Haven Health Center of New Haven</td>
<td>296</td>
</tr>
<tr>
<td>Haven Health Center of Norwich</td>
<td>762</td>
</tr>
<tr>
<td>Haven Health Center, Soundview</td>
<td>793</td>
</tr>
<tr>
<td>Haven Health Center of South Windsor</td>
<td>724</td>
</tr>
<tr>
<td>Haven Health Center of Torrington</td>
<td>818</td>
</tr>
<tr>
<td>Haven Health Center of Waterbury</td>
<td>737</td>
</tr>
<tr>
<td>Haven Health Center of Waterford</td>
<td>871</td>
</tr>
<tr>
<td>Haven Health Center of Windham</td>
<td>288</td>
</tr>
<tr>
<td>Health Resources of Wallingford Skyview</td>
<td>848</td>
</tr>
<tr>
<td>Hebrew Home and Hospital</td>
<td>804</td>
</tr>
<tr>
<td>High View Health Care Center</td>
<td>788</td>
</tr>
<tr>
<td>Hill Crest Health Care Center</td>
<td>280</td>
</tr>
<tr>
<td>Hospital for Special Care</td>
<td>073</td>
</tr>
<tr>
<td>Ingraham Manor</td>
<td>270</td>
</tr>
<tr>
<td>Jefferson House</td>
<td>859</td>
</tr>
<tr>
<td>Kettlebrook Care Center</td>
<td>684</td>
</tr>
<tr>
<td>Kimberly Hall (South)</td>
<td>718</td>
</tr>
<tr>
<td>Laurel Ridge Health Care Center</td>
<td>167</td>
</tr>
<tr>
<td>Laurel Woods Inc.</td>
<td>192</td>
</tr>
<tr>
<td>Litchfield Woods Health Care</td>
<td>890</td>
</tr>
<tr>
<td>Long Ridge of Stamford</td>
<td>187</td>
</tr>
<tr>
<td>Lord Chamberlain Nursing and Rehab Center</td>
<td>735</td>
</tr>
<tr>
<td>Maefair Health Care Center</td>
<td>157</td>
</tr>
<tr>
<td>Manchester Manor Health Care Center</td>
<td>771</td>
</tr>
<tr>
<td>Mansfield Center For Nursing and Rehab</td>
<td>159</td>
</tr>
<tr>
<td>Maple View Manor</td>
<td>772</td>
</tr>
<tr>
<td>Mariner Health at Bridebrook</td>
<td>668</td>
</tr>
<tr>
<td>Mariner Health at Pendleton</td>
<td>285</td>
</tr>
<tr>
<td>Marlborough Health Care Center</td>
<td>178</td>
</tr>
<tr>
<td>Mary Elizabeth Nursing Center</td>
<td>851</td>
</tr>
<tr>
<td>Masonic Geriatric Healthcare Center Inc.</td>
<td>082</td>
</tr>
<tr>
<td>McLean Home</td>
<td>774</td>
</tr>
<tr>
<td>Meadowbrook Of Granby</td>
<td>176</td>
</tr>
<tr>
<td>Meadow Ridge</td>
<td>57A</td>
</tr>
<tr>
<td>Mediplex of Darien</td>
<td>722</td>
</tr>
<tr>
<td>Mediplex of Greater Hartford (Subacute Care Only)</td>
<td>221</td>
</tr>
<tr>
<td>Mediplex of Milford</td>
<td>676</td>
</tr>
<tr>
<td>Mediplex of Southbury</td>
<td>747</td>
</tr>
<tr>
<td>Mediplex of Southern CT</td>
<td>854</td>
</tr>
<tr>
<td>Mediplex of Westport</td>
<td>828</td>
</tr>
<tr>
<td>Mediplex of Wethersfield</td>
<td>831</td>
</tr>
<tr>
<td>Meriden Nursing and Rehabilitation</td>
<td>778</td>
</tr>
<tr>
<td>Meridian Manor</td>
<td>776</td>
</tr>
<tr>
<td>Milford Health Care Center</td>
<td>810</td>
</tr>
<tr>
<td>Miller Memorial Community</td>
<td>864</td>
</tr>
<tr>
<td>Montowese Health and Rehabilitation Center</td>
<td>777</td>
</tr>
<tr>
<td>Plainville Healthcare Center</td>
<td>786</td>
</tr>
<tr>
<td>Portland Care and Rehabilitation Center</td>
<td>816</td>
</tr>
</tbody>
</table>
### Skilled Nursing Facilities continued

<table>
<thead>
<tr>
<th>Facility Name</th>
<th>Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>Regency House of Wallingford</td>
<td>726</td>
</tr>
<tr>
<td>Ridgeview Health Care Center</td>
<td>697</td>
</tr>
<tr>
<td>Riverside Health Care</td>
<td>870</td>
</tr>
<tr>
<td>Rose Haven, LTD</td>
<td>290</td>
</tr>
<tr>
<td>Salmon Brook Nursing and Rehab Center</td>
<td>791</td>
</tr>
<tr>
<td>Shady Knoll Health Center</td>
<td>294</td>
</tr>
<tr>
<td>Sharon Health Care Center (Subacute Care Only)</td>
<td>698</td>
</tr>
<tr>
<td>Sheridan Woods Health Care Center</td>
<td>607</td>
</tr>
<tr>
<td>Southington Care Center</td>
<td>274</td>
</tr>
<tr>
<td>Spectrum Healthcare of Waterbridge DBA Hilltop Health Center</td>
<td>168</td>
</tr>
<tr>
<td>St. Joseph Living Center</td>
<td>894</td>
</tr>
<tr>
<td>St. Regis Health Center (Subacute Care Only)</td>
<td>629</td>
</tr>
<tr>
<td>Sterling Manor, Inc.</td>
<td>713</td>
</tr>
<tr>
<td>Subacute Center of Bristol</td>
<td>708</td>
</tr>
<tr>
<td>The Highlands Health Care Center</td>
<td>752</td>
</tr>
<tr>
<td>The Summit at Plantsville</td>
<td>181</td>
</tr>
<tr>
<td>The Kent</td>
<td>195</td>
</tr>
<tr>
<td>William and Sally Tandet Center for Continuing Care</td>
<td>622</td>
</tr>
<tr>
<td>Yale-New Haven Ambulatory Services/Temple Recovery</td>
<td>237</td>
</tr>
<tr>
<td>Valerie Manor</td>
<td>875</td>
</tr>
<tr>
<td>Vernon Manor Health Care Center</td>
<td>622</td>
</tr>
<tr>
<td>Walnut Hill Convalescent Home</td>
<td>797</td>
</tr>
<tr>
<td>Waterbury Extended Care Facility</td>
<td>798</td>
</tr>
<tr>
<td>Watrous Nursing Center</td>
<td>655</td>
</tr>
<tr>
<td>Westfield Care and Rehab Center</td>
<td>800</td>
</tr>
<tr>
<td>Westview Nursing and Rehabilitation</td>
<td>801</td>
</tr>
<tr>
<td>Wilton Meadows Health Care</td>
<td>785</td>
</tr>
<tr>
<td>Windsor Rehab and Healthcare Center (Subacute Care Only)</td>
<td>845</td>
</tr>
<tr>
<td>Wintonbury Health Care Center</td>
<td>728</td>
</tr>
<tr>
<td>Wolcott Hall Nursing Center, Inc.</td>
<td>852</td>
</tr>
<tr>
<td>Wolcott View Manor</td>
<td>840</td>
</tr>
<tr>
<td>WoodLake at Tolland</td>
<td>882</td>
</tr>
</tbody>
</table>
Appendix D

Place of Service Codes

Anthem utilizes “administrative” place of service codes which correspond to the old (1991) CMS (HCFA) place of service coding scheme. Providers may use either the newer CMS place of service codes or the old codes. If a provider submits the current CMS place of service codes, our system will ‘crosswalk’ the claims to our “administrative” codes, as follows:

Be advised that our system only accepts a numeric zero as the first position.

<table>
<thead>
<tr>
<th>Current CMS Codes</th>
<th>Anthem Uses</th>
</tr>
</thead>
<tbody>
<tr>
<td>11 Office</td>
<td>03</td>
</tr>
<tr>
<td>12 Home</td>
<td>04</td>
</tr>
<tr>
<td>21 Inpatient Hospital</td>
<td>01</td>
</tr>
<tr>
<td>22 Outpatient Hospital</td>
<td>02</td>
</tr>
<tr>
<td>23 Emergency Room</td>
<td>01</td>
</tr>
<tr>
<td>24 Ambulatory Surgical Center</td>
<td>12</td>
</tr>
<tr>
<td>25 Birthing Center</td>
<td>02</td>
</tr>
<tr>
<td>26 Military Treatment Facility</td>
<td>0B</td>
</tr>
<tr>
<td>31 Skilled Nursing Home</td>
<td>08</td>
</tr>
<tr>
<td>32 Nursing Facility</td>
<td>07</td>
</tr>
<tr>
<td>33 Custodial Care Facility</td>
<td>07</td>
</tr>
<tr>
<td>34 Hospice</td>
<td>0H</td>
</tr>
<tr>
<td>41 Ambulance/Land</td>
<td>09</td>
</tr>
<tr>
<td>42 Ambulance/Air or Water</td>
<td>09</td>
</tr>
<tr>
<td>51 Inpatient Psychiatric Facility</td>
<td>01</td>
</tr>
<tr>
<td>52 Psychiatric Facility – Partial</td>
<td>05/06</td>
</tr>
<tr>
<td>53 Community Mental Health Center</td>
<td>03</td>
</tr>
<tr>
<td>54 Intermediate Care Facility/Mental Retardation</td>
<td>07</td>
</tr>
<tr>
<td>55 Residential Substance Abuse Treatment Facility</td>
<td>0D</td>
</tr>
<tr>
<td>56 Psychiatric Residential Treatment Center</td>
<td>01</td>
</tr>
<tr>
<td>61 Comprehensive Inpatient Rehabilitation Facility</td>
<td>01</td>
</tr>
<tr>
<td>62 Comprehensive Outpatient Rehabilitation Facility</td>
<td>02</td>
</tr>
<tr>
<td>65 End Stage Renal Disease Treatment Facility</td>
<td>02</td>
</tr>
<tr>
<td>71 State/Local Public Health Clinic</td>
<td>03</td>
</tr>
<tr>
<td>72 Rural Health Clinic</td>
<td>03</td>
</tr>
<tr>
<td>81 Independent Lab</td>
<td>00/A0</td>
</tr>
<tr>
<td>99 Other Unlisted</td>
<td>OL</td>
</tr>
</tbody>
</table>
Appendix E
Claim Information Required For Compensation

The services on the following list are eligible for compensation only if specific information on the services rendered is provided when the claim is filed. This information must be provided when filing claims for any of the services identified on the list, which indicates the procedure code, a description of the service and the information required.

- When filing electronically, the 80-character documentation text or the free form narrative (NSF format) must be entered.
- For manual claim submission, the information should be attached to the CMS-1500 claim form.

<table>
<thead>
<tr>
<th>CODE</th>
<th>DESCRIPTION</th>
<th>INFORMATION REQUIRED/EXAMPLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A4649</td>
<td>Surgical Supplies, miscellaneous</td>
<td>Description of Supply</td>
</tr>
<tr>
<td>A9500</td>
<td>Radiopharmaceuticals</td>
<td>Name, Strength &amp; Dosage</td>
</tr>
<tr>
<td>A9699</td>
<td>Supply of radiopharmaceutical therapeutic imaging agent, not otherwise classified</td>
<td>Name, Strength &amp; Dosage</td>
</tr>
<tr>
<td>A9900</td>
<td>Miscellaneous supply, accessory and/or service component of another HCPCS Code</td>
<td>Description of Services/Supply</td>
</tr>
<tr>
<td>G0238</td>
<td>Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face per 15 minutes (includes monitoring)</td>
<td>Description of Services Rendered</td>
</tr>
<tr>
<td>G0239</td>
<td>Therapeutic procedures to improve respiratory function, other than described by G0237, two or more (includes monitoring)</td>
<td>Description of Services Rendered</td>
</tr>
<tr>
<td>H0046</td>
<td>Mental health services, not otherwise specified</td>
<td>Description of Services Rendered</td>
</tr>
<tr>
<td>H0047</td>
<td>Alcohol and/or other drug testing; collection and handling only, specimens other than blood</td>
<td>Description of Specimens Collected</td>
</tr>
<tr>
<td>J0725</td>
<td>Injection, chorionic gonadotropin</td>
<td>Number of Units for d/o/s prior to 1/1/95</td>
</tr>
<tr>
<td>J3490</td>
<td>Unclassified drugs</td>
<td>Name of Drug, Dosage, Route of Administration</td>
</tr>
<tr>
<td>J3590</td>
<td>Unclassified biologics</td>
<td>Description of Biologic Material Used</td>
</tr>
<tr>
<td>J7199</td>
<td>Hemophilia clotting factor, not otherwise classified</td>
<td>Name, Strength, Dosage</td>
</tr>
<tr>
<td>J8499</td>
<td>Prescription drug, oral, non-chemotherapeutic, NOS</td>
<td>Name of Drug, Dosage</td>
</tr>
<tr>
<td>J8999</td>
<td>Prescription drug, oral, chemotherapeutic, NOS</td>
<td>Name of Drug, Dosage</td>
</tr>
<tr>
<td>J9999</td>
<td>Not otherwise classified, antineoplastic drugs</td>
<td>Name of Drug, Dosage, Route of Administration</td>
</tr>
<tr>
<td>S0590</td>
<td>Integral lens service, miscellaneous services reported separately</td>
<td>Description of Services</td>
</tr>
<tr>
<td>S1001</td>
<td>Deluxe item, patient aware (List in addition to code for basic item)</td>
<td>Description of Item</td>
</tr>
<tr>
<td>S1002</td>
<td>Customized item (List in addition to code for basic item)</td>
<td>Description of Item</td>
</tr>
<tr>
<td>S8199</td>
<td>Tracheostomy supply, not otherwise classified</td>
<td>Description of Item</td>
</tr>
<tr>
<td>S8415</td>
<td>Supplies for home delivery of infant</td>
<td>Description of Item</td>
</tr>
<tr>
<td>S9986</td>
<td>Not medically necessary service (patient aware not medically necessary)</td>
<td>Description of Service</td>
</tr>
<tr>
<td>S9989</td>
<td>Services provided outside the United States of America (list in addition to code(s) for service(s))</td>
<td>Description of Service</td>
</tr>
<tr>
<td>T1011</td>
<td>Alcohol and/or substance abuse services, not otherwise classified</td>
<td>Description of Services</td>
</tr>
<tr>
<td>V2199</td>
<td>Not otherwise classified, single vision lens</td>
<td>Description of Lens</td>
</tr>
<tr>
<td>V2299</td>
<td>Specialty bifocal (by report)</td>
<td>Description of Lens</td>
</tr>
<tr>
<td>V2399</td>
<td>Specialty trifocal (by report)</td>
<td>Description of Lens</td>
</tr>
<tr>
<td>V2499</td>
<td>Variable asphericity lens, other type</td>
<td>Description of Lens</td>
</tr>
<tr>
<td>V5274</td>
<td>Assistive learning device, not otherwise specified</td>
<td>Description of Item</td>
</tr>
<tr>
<td>V5298</td>
<td>Hearing aid, not otherwise classified</td>
<td>Description of Item</td>
</tr>
<tr>
<td>V5299</td>
<td>Hearing service, miscellaneous</td>
<td>Description of Service</td>
</tr>
<tr>
<td>37501</td>
<td>Unlisted vascular endoscopy procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>44238</td>
<td>Unlisted laparoscopy procedure, intestine (except rectum)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>44239</td>
<td>Unlisted laparoscopy procedure, rectum</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>76496</td>
<td>Unlisted fluoroscopic procedure (e.g., diagnostic, interventional)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>76497</td>
<td>Unlisted computed tomography procedure (e.g., diagnostic, interventional)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>76498</td>
<td>Unlisted magnetic resonance procedure (e.g., diagnostic, interventional)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>76499</td>
<td>Unlisted diagnostic radiologic procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>76970</td>
<td>Ultrasound study follow-up (specify)</td>
<td>What is Being Followed-Up</td>
</tr>
</tbody>
</table>
### Specific Claim Information Required For Compensation Continued

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>76999</td>
<td>Unlisted ultrasound procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>77499</td>
<td>Unlisted procedure, therapeutic radiology clinical treatment management</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>77799</td>
<td>Unlisted procedure, clinical brachytherapy</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78099</td>
<td>Unlisted endocrine procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78199</td>
<td>Unlisted hematopoietic, reticuloendothelial and lymphatic procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78299</td>
<td>Unlisted gastrointestinal procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78399</td>
<td>Unlisted musculoskeletal procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78499</td>
<td>Unlisted cardiovascular procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78699</td>
<td>Unlisted nervous system procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78799</td>
<td>Unlisted genitourinary procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>78999</td>
<td>Unlisted miscellaneous procedure, diagnostic nuclear medicine</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>80299</td>
<td>Quantitation of drug, not elsewhere specified</td>
<td>Specify Name of Drug</td>
</tr>
<tr>
<td>81099</td>
<td>Unlisted urinalysis procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>83516</td>
<td>Immunoassay for analyte other than antibody or infectious agent antigen, qualitative or semiquantitative; multiple step method</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>83518</td>
<td>Immunoassay for analyte other than antibody or infectious agent antigen, qualitative or semiquantitative; single step method (e.g., reagent strip)</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>83519</td>
<td>Immunoassay, analyte, quantitative; by radiopharmaceutical technique (e.g., RIA)</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>83520</td>
<td>Immunoassay, analyte, quantitative; not otherwise specified</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>84999</td>
<td>Unlisted chemistry procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>85999</td>
<td>Unlisted hematology and coagulation procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>86005</td>
<td>Allergen specific IgE; qualitative, multiallergen screen (dipstick or disk)</td>
<td>Specify Allergens</td>
</tr>
<tr>
<td>86318</td>
<td>Immunoassay for infectious agent antibody, qualitative or semiquantitative; single step method (e.g., reagent strip)</td>
<td>Specify Infectious Agent Antibody Tested</td>
</tr>
<tr>
<td>86849</td>
<td>Unlisted immunology procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>86999</td>
<td>Unlisted transfusion medicine procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>87299</td>
<td>Infectious agent antigen detection by direct fluorescent antibody technique, not otherwise specified</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>87999</td>
<td>Unlisted microbiology procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>88199</td>
<td>Unlisted cytopathology procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>88299</td>
<td>Unlisted cytogenetic study</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>88399</td>
<td>Unlisted surgical pathology procedure</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>89399</td>
<td>Unlisted miscellaneous pathology test</td>
<td>Specify Test Performed</td>
</tr>
<tr>
<td>90399</td>
<td>Unlisted immune globulin</td>
<td>Name of Drug, Strength &amp; Dosage</td>
</tr>
<tr>
<td>90749</td>
<td>Unlisted immunization procedure</td>
<td>Name of Serum, Dosage &amp; Route of Administration</td>
</tr>
<tr>
<td>90899</td>
<td>Unlisted psychiatric service or procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>92700</td>
<td>Unlisted otorhinolaryngological service or procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>96549</td>
<td>Unlisted chemotherapy procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>97039</td>
<td>Unlisted modality (specify type and time if constant attendance)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>97139</td>
<td>Therapeutic procedure, one or more areas, each 15 minutes; unlisted therapeutic procedure (specify)</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>97799</td>
<td>Unlisted physical medicine service or procedure</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>99070</td>
<td>Supplies and materials (except spectacles) provided by the physician over and above those usually included with the office visit or other services rendered (list drugs, trays, supplies, or materials provided)</td>
<td>Description of Materials Provided</td>
</tr>
<tr>
<td>99080</td>
<td>Special reports such as insurance forms, more than the information conveyed in the usual medical communications or standard reporting form</td>
<td>Description of Services Rendered</td>
</tr>
<tr>
<td>99090</td>
<td>Analysis of clinical data stored in computers (e.g. ECGs, blood pressures, hematologic data)</td>
<td>Specify Type of Data</td>
</tr>
<tr>
<td>99199</td>
<td>Unlisted special service or report</td>
<td>Description of Service Rendered</td>
</tr>
<tr>
<td>99600</td>
<td>Unlisted home visit service or procedure</td>
<td>Description of Service Rendered</td>
</tr>
</tbody>
</table>
Appendix F

National Directory of Blue Cross & Blue Shield Plans

See Claims Submission section for details on the out-of-area claims processing program

<table>
<thead>
<tr>
<th>Plan State</th>
<th>Plan Name/Address</th>
<th>Plan Code</th>
<th>Alpha Prefix</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALABAMA</td>
<td>Blue Cross and Blue Shield of Alabama</td>
<td>BC 010</td>
<td>XA</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 995, Birmingham, AL 35298</td>
<td>BS 510</td>
<td></td>
</tr>
<tr>
<td>ALASKA</td>
<td>Primera Blue Cross</td>
<td>BC 430</td>
<td>ZK</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 327, Seattle, WA 98111-0327</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ARIZONA</td>
<td>Blue Cross and Blue Shield of Arizona, Inc.</td>
<td>BC 030</td>
<td>XB</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 13466, Phoenix, AZ 85002-3466</td>
<td>BS 530</td>
<td></td>
</tr>
<tr>
<td>ARKANSAS</td>
<td>Arkansas Blue Cross &amp; Blue Shield</td>
<td>BC 020</td>
<td>XC</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 2181, Little Rock, AR 72203</td>
<td>BS 520</td>
<td></td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>Blue Cross of California</td>
<td>BC 040</td>
<td>XD</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 7000, Van Nuys, CA 91470</td>
<td>BS 542</td>
<td>XE</td>
</tr>
<tr>
<td></td>
<td>Blue Shield of California</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>P.O. Box 7168, San Francisco, CA 94120</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COLORADO</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>BC 050</td>
<td>XF</td>
</tr>
<tr>
<td></td>
<td>700 Broadway, Denver, CO 80273</td>
<td>BS 550</td>
<td></td>
</tr>
<tr>
<td>CONNECTICUT</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>BC 060</td>
<td>XG</td>
</tr>
<tr>
<td></td>
<td>370 Bassett Road, North Haven, CT 06473</td>
<td>BS 560</td>
<td></td>
</tr>
<tr>
<td>DELAWARE</td>
<td>Blue Cross and Blue Shield of Delaware, Inc.</td>
<td>BC 070</td>
<td>XH</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1991, Wilmington, DE 19899</td>
<td>BS 570</td>
<td></td>
</tr>
<tr>
<td>DISTRICT OF COLUMBIA</td>
<td>Blue Cross and Blue Shield of the Ntl.Capital Area</td>
<td>BC 080</td>
<td>XI</td>
</tr>
<tr>
<td></td>
<td>550 12th Street, S.W., Washington, DC 20065</td>
<td>BS 580</td>
<td></td>
</tr>
<tr>
<td>FLORIDA</td>
<td>Blue Cross and Blue Shield of Florida, Inc.</td>
<td>BC 090</td>
<td>XJ</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1798, Jacksonville, FL 32231-0014</td>
<td>BS 590</td>
<td></td>
</tr>
<tr>
<td>GEORGIA</td>
<td>Blue Cross and Blue Shield of Georgia, Inc.</td>
<td>BC 100</td>
<td>XK</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 4445, Atlanta, GA 30302-4445</td>
<td>BS 600</td>
<td></td>
</tr>
<tr>
<td>HAWAII</td>
<td>Blue Cross &amp; Blue Shield of Hawaii</td>
<td>BC 471</td>
<td>XL</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 860, Honolulu, HI 96808-0860</td>
<td>BS 971</td>
<td></td>
</tr>
<tr>
<td>IDAHO</td>
<td>Regence BlueShield of Idaho</td>
<td>BS 611</td>
<td>XN</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1106, Lewiston, ID 83501</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ILLINOIS</td>
<td>Blue Cross and Blue Shield of Illinois</td>
<td>BC 121</td>
<td>XO</td>
</tr>
<tr>
<td></td>
<td>P.O. Box 1364, Chicago, IL 60690</td>
<td>BS 621</td>
<td></td>
</tr>
<tr>
<td>State</td>
<td>Company Name</td>
<td>Address</td>
<td>Code 1</td>
</tr>
<tr>
<td>-----------</td>
<td>--------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>--------</td>
</tr>
<tr>
<td>Indiana</td>
<td>Anthem Insurance Companies, Inc.</td>
<td>120 Monument Circle, Indianapolis, IN 46204</td>
<td>BC 130</td>
</tr>
<tr>
<td></td>
<td><em>Anthem Blue Cross and Blue Shield</em></td>
<td></td>
<td>BS 630</td>
</tr>
<tr>
<td>Iowa</td>
<td>Wellmark Blue Cross and Blue Shield of Iowa</td>
<td>636 Grand Avenue, Des Moines, IA 50309</td>
<td>BC 140</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 640</td>
</tr>
<tr>
<td>Kansas</td>
<td>Blue Cross and Blue Shield of Kansas, Inc.</td>
<td>P.O. Box 239, Topeka, KS 66601-0239</td>
<td>BC 150</td>
</tr>
<tr>
<td></td>
<td><em>Anthem Blue Cross and Blue Shield</em></td>
<td></td>
<td>BS 650</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>9901 Linn Station Road, Louisville, KY 40223</td>
<td>BC 160</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 660</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Blue Cross and Blue Shield of Louisiana</td>
<td>P.O. Box 98029, Baton Rouge, LA 70898-9029</td>
<td>BC 170</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 670</td>
</tr>
<tr>
<td>Maine</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>2 Gannett Drive, South Portland, ME 04106-6911</td>
<td>BC 180</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 680</td>
</tr>
<tr>
<td>Maryland</td>
<td>Maryland (Care First Blue Cross Blue Shield)</td>
<td>P.O. Box 1010, Owings Mills, MD 21117</td>
<td>BC 190</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 690</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Blue Cross &amp; Blue Shield of Massachusetts, Inc.</td>
<td>100 Summer Street, Boston, MA 02110</td>
<td>BC 200</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 700</td>
</tr>
<tr>
<td>Michigan</td>
<td>Blue Cross and Blue Shield of Michigan</td>
<td>600 Lafayette East, Detroit, MI 48226-2998</td>
<td>BC 210</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 710</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Blue Cross and Blue Shield of Minnesota</td>
<td>P.O. Box 64560, St. Paul, MN 55164-0560</td>
<td>BC 220</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 720</td>
</tr>
<tr>
<td>Mississippi</td>
<td>Blue Cross &amp; Blue Shield of Mississippi</td>
<td>P.O. Box 1043, Jackson, MS 39215-1043</td>
<td>BC 230</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 730</td>
</tr>
<tr>
<td>Missouri</td>
<td>Blue Cross and Blue Shield of Kansas City</td>
<td>Box 419169, Kansas City, MO 64141-6169</td>
<td>BC 240</td>
</tr>
<tr>
<td></td>
<td>Alliance Blue Cross Blue Shield</td>
<td>1831 Chestnut Street, St. Louis, MO 63103-2275</td>
<td>BC 241</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 741</td>
</tr>
<tr>
<td>Montana</td>
<td>Blue Cross and Blue Shield of Montana, Inc.</td>
<td>P.O. Box 4309, Helena, MT 59604</td>
<td>BC 250</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 751</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Blue Cross and Blue Shield of Nebraska</td>
<td>P.O. Box 3248, Main P.O. Station, Omaha, NE 68180-0001</td>
<td>BC 260</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 760</td>
</tr>
<tr>
<td>Nevada</td>
<td>Blue Cross and Blue Shield of Nevada</td>
<td>P.O. Box 10330, Reno, NV 89520-0330</td>
<td>BC 265</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 765</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>3000 Goffs Falls Road, Manchester, NH 03111-0001</td>
<td>BC 270</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 770</td>
</tr>
<tr>
<td>New Jersey</td>
<td>Blue Cross and Blue Shield of New Jersey, Inc.</td>
<td>3 Penn Plaza East, Newark, NJ 07105</td>
<td>BC 280</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>BS 780</td>
</tr>
<tr>
<td>State</td>
<td>Company Name</td>
<td>Address</td>
<td>BC</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------------------------------------------------------</td>
<td>----------------------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>NEW MEXICO</td>
<td>Blue Cross and Blue Shield of New Mexico</td>
<td>P.O. Box 27630, Albuquerque, NM 87125-7630</td>
<td>290</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>Blue Cross and Blue Shield of Western NY</td>
<td>P.O. Box 80, Buffalo, NY 14240</td>
<td>301</td>
</tr>
<tr>
<td></td>
<td>Empire Blue Cross and Blue Shield</td>
<td></td>
<td>303</td>
</tr>
<tr>
<td></td>
<td>Blue Cross and Blue Shield of Central NY</td>
<td>P.O. Box 4809, Syracuse, NY 13221-4809</td>
<td>305</td>
</tr>
<tr>
<td></td>
<td>Blue Cross and Blue Shield of Utica-Watertown</td>
<td>Utica Business Park, 12 Rhoads Drive</td>
<td>306</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>Blue Cross and Blue Shield of North Carolina</td>
<td>P.O. Box 2291, Durham, NC 27720</td>
<td>310</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>Blue Cross Blue Shield of North Dakota</td>
<td>4510 13th Avenue, SW, Fargo, ND 58121-0001</td>
<td>320</td>
</tr>
<tr>
<td>OHIO</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>1351 William Howard Taft Road, Cincinnati, OH 45206</td>
<td>332</td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>Blue Cross and Blue Shield of Oklahoma</td>
<td>P.O. Box 3283, Tulsa, OK 74102-3283</td>
<td>340</td>
</tr>
<tr>
<td>OREGON</td>
<td>Regence BlueCross BlueShield of Oregon</td>
<td>P.O. Box 1271, Portland, OR 97207</td>
<td>350</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>Highmark Blue Cross and Blue Shield</td>
<td>120 Fifth Avenue, Pittsburgh, PA 15222-3099</td>
<td>363</td>
</tr>
<tr>
<td></td>
<td>Capital Blue Cross</td>
<td>2500 Elmerton Avenue, Harrisburg, PA 17110</td>
<td>361</td>
</tr>
<tr>
<td></td>
<td>Independence Blue Cross</td>
<td>P.O. Box 13400, Philadelphia, PA 19107</td>
<td>362</td>
</tr>
<tr>
<td></td>
<td>Blue Cross of Northeastern Pennsylvania</td>
<td>70 North Main Street, Wilkes-Barre, PA 18711</td>
<td>364</td>
</tr>
<tr>
<td>PUERTO RICO</td>
<td>Triple-S, Inc.</td>
<td>P.O. Box 363628, San Juan, PR 00936-3628</td>
<td>973</td>
</tr>
<tr>
<td></td>
<td>LaCruz Azul de Puerto Rico</td>
<td>P.O. Box 366068, San Juan, PR 00936-6068</td>
<td>470</td>
</tr>
<tr>
<td>State</td>
<td>Name</td>
<td>Address</td>
<td>BC</td>
</tr>
<tr>
<td>---------------</td>
<td>----------------------------------------------------------------------</td>
<td>-----------------------------------</td>
<td>-----</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>Blue Cross &amp; Blue Shield of Rhode Island</td>
<td>444 Westminster Street, Providence, RI 02903-3279</td>
<td>BC 370</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>Blue Cross and Blue Shield of South Carolina</td>
<td>1-20 East at Alpine Road, Columbia, SC 29219</td>
<td>BC 380</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>Wellmark Blue Cross and Blue Shield of SD</td>
<td>1601 West Madison Street, Sioux Falls, SD 57104</td>
<td>BC 141</td>
</tr>
<tr>
<td>TENNESSEE</td>
<td>Blue Cross and Blue Shield of Tennessee-Chattanooga</td>
<td>801 Pine Street, Chattanooga, TN 37402</td>
<td>BC 390</td>
</tr>
<tr>
<td>TEXAS</td>
<td>Blue Cross and Blue Shield of Texas, Inc.</td>
<td>P.O. Box 655730, Dallas, TX 75265-5730</td>
<td>BC 400</td>
</tr>
<tr>
<td>UTAH</td>
<td>Regence BlueCross BlueShield of Utah</td>
<td>P.O. Box 30270, Salt Lake City, UT 84130-0270</td>
<td>BC 410</td>
</tr>
<tr>
<td>VERMONT</td>
<td>Blue Cross and Blue Shield of Vermont</td>
<td>P.O. Box 186, Berlin, VT 05601</td>
<td>BC 415</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>P.O. Box 27401, Richmond, VA 23279</td>
<td>BC 423</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>Northwest Washington Medical Bureau</td>
<td>333 Gilkey Road, Burlington, VW 98233-2823</td>
<td>BC 430</td>
</tr>
<tr>
<td></td>
<td>Premera Blue Cross</td>
<td>P.O. Box 327, Seattle, WA 98111-0327</td>
<td>BS 430</td>
</tr>
<tr>
<td></td>
<td>Regence BlueShield</td>
<td>P.O. Box 21267, Seattle, WA 98111-3267</td>
<td>BS 932</td>
</tr>
<tr>
<td></td>
<td>Primera Blue Cross</td>
<td>P.O. Box 3048, Spokane, WA 99220</td>
<td>BS 934</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>Mountain State Blue Cross &amp; Blue Shield, Inc.</td>
<td>P.O. Box 1948, Parkersburg, WV 26102</td>
<td>BC 443</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>Blue Cross &amp; Blue Shield United of Wisconsin</td>
<td>P.O. Box 2025, Milwaukee, WI 53201</td>
<td>BC 450</td>
</tr>
<tr>
<td>WYOMING</td>
<td>Blue Cross and Blue Shield of Wyoming</td>
<td>P.O. Box 2266, Cheyenne, WY 82003-2266</td>
<td>BC 460</td>
</tr>
</tbody>
</table>