TABLE OF CONTENTS

SECTION 1
About this Manual .........................................................................................................................4
Use of Proprietary Information ......................................................................................................5

SECTION 2
Care Management / Quality Management Programs....................................................................5
Referral and Triage .......................................................................................................................5
Medical Necessity .........................................................................................................................5
Clinical Criteria .............................................................................................................................6
Levels of Care ...............................................................................................................................6
Practice Guidelines .......................................................................................................................7
Coordination of Care .....................................................................................................................7
Prior Authorization Process .........................................................................................................7
Complaints and Appeals ...............................................................................................................9
Appeal/Grievance Process ............................................................................................................9
Clinical Quality Improvement Activities .......................................................................................10
Provider Satisfaction Surveys ....................................................................................................12

SECTION 3
Network Participation ..................................................................................................................11
Network Selection ......................................................................................................................11
Participating Physician, Provider and Group Agreements .........................................................11
About our Agreements ...............................................................................................................11
Credentialing Process ..............................................................................................................12
Professional Practitioner Credentialing .......................................................................................12
Facility/Program Credentialing ...................................................................................................12
Recredentialing ..........................................................................................................................12
On-going Monitoring ..................................................................................................................12
Provider Sanctions and Termination ..........................................................................................12
Network Termination ................................................................................................................13
Rights and Obligations upon Termination ................................................................................13
Members’ Rights to Continuing Treatment When Network Participation Ends ....................13

SECTION 4
Provider Responsibilities ............................................................................................................13
Provider Coverage .....................................................................................................................14
Duty to Warn ...............................................................................................................................14
Required Reporting............................................................................................................. 14
Use of Name ............................................................................................................................... 14
Site Visits .................................................................................................................................... 14
Treatment Record Standards..................................................................................................... 15
SECTION 5
Members’ Rights and Responsibilities ........................................................................................15
Non-Discrimination Policy ........................................................................................................... 15
Confidentiality of Patient Records............................................................................................. 15
Member Rights & Responsibilities Statement............................................................................. 15
SECTION 6
Claims Procedures.............................................................................................................. 16
Participating Provider Payment Policy ........................................................................................16
Members Held Harmless............................................................................................................. 16
Patient Balance Billing Prohibited ...............................................................................................16
Missed Appointment Policy ....................................................................................................... 16
Maximum Visits Per Day ......................................................................................................... .... 16
Secondary Coverage .................................................................................................................. 16
Incomplete Claims.......................................................................................................................16
Claim Submission Guidelines - Paper and Electronic.................................................................16
Coordination of Benefits.......................................................................................................... 17
SECTION 7 .................................................................................................................................19
Attachments
A. Clinical Treatment Record Standards and Audit Summary
B. Outpatient Treatment Report Form
SECTION 1
About this Manual

This manual has been prepared and issued by Anthem Behavioral Health (AB). It contains important information about our policies and procedures for physicians, practitioners, group practices, service programs and facilities. It also supplements your Participating Provider/Facility Agreement with Anthem Blue Cross and Blue Shield (Anthem). Revisions are issued periodically; important updates communicated through our provider newsletters. Please remember to incorporate these updates into your manual.

We reserve the right to amend this manual, and retain the right to interpret any terms or provisions.

The following terms are used frequently in this manual:

- **Participating provider** means a duly licensed provider, including a physician, a non-physician practitioner, a hospital, a residential treatment facility, and a mental health or substance abuse treatment clinic that has entered into a written agreement to provide covered services to Anthem members.

- **Payer** refers to a person or entity that is liable for funding payments under a Plan.

- **Plan** means any health plan this is sponsored, underwritten or administered by Anthem or by an entity with which Anthem has agreed to provide access to the applicable network of Participating Providers, as any Plan may be amended from time to time.

- **Program or product** means the health maintenance organization (HMO), preferred provider organization (PPO) or other types of health delivery models, administrative services, Plan designs and product descriptions that are provided or arranged by Anthem and that are specifically described in this Administrative Policies and Procedures Manual.

Members Served

We administer the behavioral health benefits for many Anthem members. Please refer to the back of your patient’s health plan ID card to confirm that we manage that person’s behavioral benefits.

Anthem Behavioral Health

The home office of AB East is located at: 370 Bassett Road, North Haven, CT 06473

**To certify/authorize services:** We maintain a toll-free access telephone line that links members with clinical intervention services 24 hours a day, seven (7) days a week. Providers may use the toll-free number to reach our care management department to certify or authorize services. The toll-free number is **800-755-0851**.

**For claims information and general inquiries:** Providers may call **800-832-6011** during business hours from 8:00 a.m.-5:00 p.m., Monday through Friday.

Anthem and AB are staffed with dedicated professionals who are able to assist you with the following:

- **Customer/Provider Service**
  - Verification of member benefits
  - Authorization procedures
  - Claim submission and status

- **Care Management**
  - Referral services
  - Authorization issues

- **Provider Relations**
  - Network participation
  - Credentialing/contracting
Use of Proprietary Information

All information, policies, procedures, systems, protocols, utilization and financial data provided to participating providers by AB or Anthem is confidential and proprietary. It should only be used by participating providers when performing their responsibilities under the Participating Provider Agreement.

If you leave the AB provider network for any reason, you should cease use of and return to AB all such proprietary information immediately.

SECTION 2

Care Management / Quality Management Programs

Our goal is to facilitate the delivery of quality behavioral health care through the effective use of resources, while measuring outcomes and satisfaction via continuous quality improvement methodologies.

The objectives of the Care Management and the Quality Management Program include:

- providing access to or help arrange for cost efficient, quality behavioral healthcare
- assessing the needs of members and facilitate access to appropriate health care resources
- administering benefits in a consistent manner based on objective information and criteria
- maximizing availability of resources for behavioral health care by facilitating the provision of proactive coordinated care in ambulatory and facility based settings, and
- continually improving the quality of our services.

We recognize that our goals and objectives will only be accomplished through collaboration and communication with physicians, practitioners, and providers as well as with members. We use nationally accepted guidelines and criteria in its care management and quality management programs.

Referral and Triage

Members may access behavioral health services through self-referral, through AB, or by referral from another practitioner or provider.

We have adopted the following standards to help ensure members have prompt access to behavioral health care:

- **Non-life threatening emergency needs - must be seen within six (6) hours.** When the severity or nature of presenting symptoms is intolerable but not life threatening to the member.

- **Urgent needs - must be seen within 48 hours.** Urgent calls concern members whose ability to contract for their own safety, or the safety of others may be time-limited, or in response to a catastrophic life event or indications of active substance use or threat of relapse. Urgent needs have the potential to escalate into an emergency without clinical intervention.

- **Routine office visit - must be within 10 business days.** Routine calls concern members who present no immediate distress and can wait to schedule an appointment without any adverse outcomes.

We use several methods to monitor adherence to these standards. Monitoring is accomplished by a) assessing the availability of appointments via phone calls by our staff to the provider’s office; b) analysis of member complaint data and c) analysis of member satisfaction. Providers are expected to make best efforts to meet these access standards for all members.
We maintain a toll-free member access telephone line 24 hours a day, seven (7) days a week. Referral assistance is available to members and providers. For emergent and urgent calls, members are referred to in-network providers. Routine referrals are made during normal business hours.

**Medical Necessity**

Medical necessity criteria have been developed by an internal committee of care managers and psychiatric advisors, then reviewed and approved by a panel of outside practicing clinicians. These criteria are reviewed on an annual basis and are based on current psychiatric literature including the criteria of the American Psychiatric Association, the American Academy of Child and Adolescent Psychiatry and the American Society for Addiction Medicine.

Medical necessity criteria are guidelines used by utilization review and care management staff (licensed registered nurse or licensed independent behavioral health practitioners). When clinical information given meets these criteria, the cases may be certified by the utilization review or care manager. When cases do not meet these criteria, cases must be sent to a psychiatrist reviewer/peer clinical reviewer for an assessment of the case. For experimental and investigational procedures and services, refer to the Plan policy and Evidence of Coverage on such procedures and services.

“Medically necessary” or “medical necessity” refers to health care services that a physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with generally accepted standards of medical practice; (b) clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient’s illness, injury or disease; and (c) not primarily for the convenience of the patient, physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient’s illness, injury or disease. For these purposes, “generally accepted standards of medical practice” means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and the views of physicians practicing in relevant clinical areas and any other relevant factors.

**Clinical Criteria**

We utilize an internally developed written utilization review decision protocol based on reasonable medical evidence to assist in determining medical necessity. The criteria were designed specifically for managed behavioral healthcare, and are reviewed on an ongoing basis by the National Clinical Advisory Committee. Adult, as well as Child and Adolescent Level of Care Criteria are used for each level of care setting. These criteria contain general elements, which are required in all criteria sets, as well as specific admission and continued stay criteria for each criteria set. To get detailed copies of the criteria, please visit our website at [anthem.com > Provider > Maine > Anthem Behavioral Health](https://anthem.com).

**Levels of Care**

Below is a brief description of the more commonly used levels of care. Alternative levels of care may be provided on an individual basis under the case management program.

- **Acute inpatient:** When a patient presents in crisis with acute symptoms and severe deterioration in functioning stemming from a DSM-IV diagnosis, and when the acute symptoms and/or functional deterioration cannot safely be managed in a less intensive setting, the appropriate intervention may include an admission to a medically safe inpatient environment. This is the most restrictive and intensive setting, and provides 24 hours a day, seven (7) days a week skilled nursing care, daily medical care, availability of psychiatrists and other physicians 24 hours a day, intensive multidisciplinary assessment and treatment. Structured activities are available throughout the day and evening, and discharge planning begins on admission.

- **23-hour observation:** When a patient presents in crisis, an appropriate intervention may include a facility-based form of crisis stabilization that provides a medically safe environment for a period of up to 23 hours. During such time, the patient can be assessed, initially treated, stabilized, and possibly triaged to a lower level of care. The results of the assessment and the patient’s response to treatment guide the recommendation as to the most appropriate level of care. An admission to a 23-hour bed also affords the opportunity to mobilize the patient’s social support network. 23-hour observation provides a setting as restrictive and intensive as acute inpatient. This may be the
most appropriate level of care for patients, who may show evidence of a psychiatric emergency, but there is the possibility that the symptoms may resolve quickly with intensive treatment and/or further evaluation before an inpatient admission is recommended.

- **Partial hospitalization:** Partial hospitalization (sometimes called day treatment) is a structured, short-term treatment modality that offers nursing care and active treatment in a program that is operable at a minimum of six (6) hours per day, five (5) days per week. Patients must attend a minimum of six (6) hours per day when participating in a partial program. Patients are not cared for on a 24-hour per day basis, and typically leave the program each evening and/or weekends. Partial hospitalization treatment is provided by a multidisciplinary treatment team, which includes a psychiatrist. Partial hospitalization is an alternative to acute inpatient hospital care and offers intensive, coordinated, multidisciplinary clinical services for patients that are able to function in the community at a minimally appropriate level and do not present an imminent potential for harm to themselves or others.

- **Intensive outpatient treatment:** Intensive outpatient is a structured, short-term treatment modality that provides a combination of individual, group and family therapy. Intensive outpatient programs meet at least three times per week, providing a minimum of three hours of treatment per session. Intensive outpatient programs must be supervised by a licensed mental health professional. Intensive outpatient treatment is an alternative to inpatient or partial hospital care and offers intensive, coordinated, multidisciplinary services for patients with an active psychiatric or substance related illness that are able to function in the community at a minimally appropriate level and present no imminent potential for harm to themselves or others.

- **Traditional outpatient:** These are services that are generally provided in an office setting for an individual who is diagnosed as having, or there is strong evidence that the patient has a DSM IV diagnosis that requires and is likely to respond to treatment. Services may include individual, group, and family therapy, and medication management.

### Practice Guidelines

We recognize the need for reducing variation in practice patterns among providers while maintaining the ability for individuality based upon patient needs. Practice guidelines have been adopted for use by network providers. These guidelines are based upon published research and expert consensus. Additional guidelines are adopted, as needed, based on population needs such as high-risk or high-volume diagnoses or services. Current practice guidelines include those for treating individuals with depressive disorders and substance use disorders.

Complete copies of these practice guidelines are available at anthem.com > Provider > Maine > Anthem Behavioral Health.

### Coordination of Care

**Between behavioral health and medical providers**

We require participating providers to initiate and maintain timely communications with members’ primary care physicians (PCP). This helps promote sharing of clinical information for comprehensive treatment and continuity of care, when appropriate, e.g. in cases of possible coexisting medical conditions, when medications are prescribed or other medical concerns are evidenced. At the time of the initial appointment or earliest practical time thereafter, providers should discuss with the member the importance of coordinated care and seek their consent to communicate with their PCP.

**Between behavioral health providers providing treatment to the same patient**

We also require participating providers to initiate and maintain contact with other behavioral health providers or consultants and health care institutions where appropriate. In these situations, the behavioral health primary clinician should discuss the importance of communication with other behavioral health providers or consultants/ institutions and seek the member’s consent to communicate with the other providers.

*Communication should be initiated early in the treatment, and maintained with periodic updates.*

The following information should be communicated:

- Diagnosis
Providers should assess members for possible coexisting medical conditions throughout the course of treatment and exchange information with members’ primary care physician about any findings. AB will work with the health plan to assist members in obtaining necessary services and follow-up medical treatment as needed to provide continuity and coordination of care, and is also available to assist you.

**Prior Authorization Process for Intensive Services (in-patient, partial hospital and intensive outpatient)**

It is the responsibility of the provider to verify the eligibility of each member at the start of treatment. This may be done by calling the behavioral health phone number on the back of the member’s health plan ID card. When you contact AB for authorization, you will be given the status of the member's coverage and applicable member cost shares. If you have questions about the benefits available or authorization process for any treatment, ask an AB provider service representative.

Members may have an HMO product or a point-of-service (POS) product. AB participating facilities must be used for HMO or in-network POS benefits. An exception would be in the case of a life threatening emergency. For outpatient treatment, AB participating providers must be used for HMO or in-network POS benefits.

**As a participating provider, you are required to comply with all certification / authorization review processes.**

All care management reviews are conducted by our care management department. All care managers are licensed behavioral health professionals, with a minimum of three years clinical experience. All of our physician reviewers are board certified and licensed. A physician is available to discuss any denial decision.

The following is a brief overview of various processes with which you may be involved.

**Prior Authorization for Intensive Services**

All admissions to inpatient, partial hospital or intensive outpatient programs must be prior authorized and are included in the continued stay review program. Prior authorization is accomplished through a discussion between the treating provider (or his/her representative) and an AB care manager. The participating provider should be prepared to discuss the following relevant clinical information during initial and concurrent authorization reviews:

- **Diagnosis (DSM IV, Axis I-V)**
- **Approximate date of onset of illness**
- **Reason for admission, precipitant(s) to admission**
- **Psychiatric history including treatment history**
- **Substance abuse history**
  - If yes:
    - *Substances used, amounts, frequency, route?*
    - *Periods of sobriety? Last use?*
    - *Legal/occupational/family/interpersonal factors*
    - *Withdrawal symptoms*
    - *Physical problems*
    - *Treatment History*
    - *AA Involvement/Attendance*
- **Family history**
- **Lethality, as evidenced by:**
  - *Suicidal? Contract for safety? (explain)*
  - *Previous attempts? (explain)*
  - *Homicidal? Contract for safety? (explain)*
  - *Previous attempts? (explain)*
- **Overt aggression**
- **Level of restriction**
- Functional impairment
- Response to previous treatment
- Treatment goals and plan (estimated length of stay, specific interventions, precautions for risk behavior)
- Medication (dosages and responses)
- Family involvement
- Expected outcomes
- Discharge plan
- Communication with medical and other behavioral health providers

The care manager will discuss the information with you and will either authorize a specific number of days or services, or will refer the case to a medical director, or other appropriate clinical peer reviewer for upper-level review. If the care manager cannot authorize the requested level of care, and no other option is felt to be appropriate by you as the treating provider, the case will be referred to a clinical peer reviewer for upper-level review. The clinical peer reviewer may contact you directly to discuss the case. On concurrent review, in addition to the above information, the care manager will be discussing the patient’s response to treatment, and progress toward discharge.

It is essential that each patient has an outpatient appointment scheduled within seven days of discharge, and that he/she have a written reminder of this appointment upon discharge. This requires the cooperation of the facility as well as the physician. We review compliance with this requirement. If there is an obstacle to this occurring, please call the care manager to discuss.

**Emergency Authorization** for life-threatening emergency conditions may be authorized up to 48 hours following an emergency admission. We will review the admission for medical necessity upon notification.

**Prior Authorization of Outpatient Services**

Twelve outpatient visits per provider number per calendar year are available without prior authorization. If additional sessions are needed beyond the initial twelve sessions, an *Outpatient Treatment Report* (OTR) is required (Attachment B). It is your responsibility, as the provider of care, to fill out the OTR and send it to us. An AB care manager will review the information, and either authorizes a specific number of sessions within a specific period, or may request additional information from you. If the care manager cannot authorize care, the case will be referred for peer review. However, when necessary, direct telephone dialogue between UM staff and providers will be initiated to provide education regarding UM practices or to clarify a treatment plan that is vague or unclear. Symptom and diagnostic information will be considered to determine if a specific approved clinical protocol applies. If so, then this protocol will be used to evaluate the proposed treatment plan. If a specific protocol does not exist for the diagnostic picture, general UM clinical criteria for outpatient care will be utilized along with member benefit coverage. Clinical protocols can be found at anthem.com > Provider > Maine > Anthem Behavioral Health.

**Ambulatory Services**: ambulatory detoxification and ECT must be prior authorized via a telephone call to us.

**Response Timeframes**

All authorizations are conducted according to the timeliness standards established by us, unless law requires a shorter timeframe. All response times begin from receipt of all necessary information required to conduct the review.

<table>
<thead>
<tr>
<th>Type of Review Request</th>
<th>Determination Made Within</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Prior Authorization</td>
<td>1 calendar day</td>
</tr>
<tr>
<td>Non-Urgent Prior Authorization</td>
<td>1 business day</td>
</tr>
<tr>
<td>Continued Stay Review</td>
<td>1 business day</td>
</tr>
<tr>
<td>Outpatient Treatment Review</td>
<td>1 business day</td>
</tr>
<tr>
<td>Retrospective Review</td>
<td>30 business days</td>
</tr>
</tbody>
</table>
Anthem Behavioral Health Administrative Policies and Procedures Provider Manual  September 2008

Complaints and Appeals
You are welcome to express to us your concerns regarding our services. We will work to address your concerns as quickly as possible. All complaints are recorded and analyzed for opportunities for us to improve the quality of our service.

Members and their providers may request an appeal of any clinical determination issued by us. Appeals are considered by licensed clinical peer reviewers. Procedures for filing an appeal are described in “Appeal/Grievance Process.”

Appeal/Grievance Process for Members Residing in the State of Maine

How to obtain information about the appeal process: The Appeal/Grievance process is available to the member, the member’s duly authorized representative, the provider of record, or the provider of record’s duly authorized representative. Questions may be posed about issues concerning the health benefit plan, including benefit determinations and care provided. Providers may contact us following an adverse determination for a peer consultation on the decision. Since most questions can be resolved informally, the first step in the dispute process is to contact an AB member services representative, at the number on the back of the member’s identification card, for additional information.

First Level Appeal:

If a determination is not satisfactory, a first level appeal review may be requested. The first level appeal review request can be initiated orally or in writing within 180 days from the date of the receipt of the initial determination. Written first level appeal review requests should be mailed to:

Anthem Behavioral Health
First Level Appeal Review
370 Bassett Road, Bldg 3 Floor 2
North Haven, CT 06473
Attn: Quality Department Appeals Coordinator

Our appeals coordinator, along with appropriate administrative or clinical specialists, if necessary, will review the entire record of appeal, including any additional supporting documentation submitted with the appeal, and will research and respond to issues raised. We will issue a written decision within 20 working days of receipt of the request for an appeal.

An appeal of a medical necessity determination may be handled in an expedited manner if waiting for the appeal to be resolved using standard appeal time frames would seriously jeopardize our member’s life, health, or ability to regain maximum functioning. An expedited review will be completed within 72 hours after the request is initiated. The determination will be relayed via telephone, with written communication to be issued within two business days. An oral request for an expedited appeal may be initiated by the covered person or the provider acting on behalf of the covered person.

Once a decision is issued, the member or member representative, if dissatisfied with the outcome, may submit a voluntary second level appeal to Anthem, request an external review, file a complaint with the Bureau of Insurance and/or bring legal action against Anthem. If the member or member representative chooses to pursue a voluntary second level appeal, they will have the opportunity to appear before the review panel to present member concerns regarding our adverse benefit determination.

Second Level Appeal (Voluntary)

The member or member representative, if dissatisfied with the outcome of the first level appeal, may appeal the decision to the Appeals Department at Anthem within 180 calendar days of the date the first level appeal decision was issued, unless there are extenuating circumstances. The second level appeal must be in writing and include specific reasons the member or authorized representative does not agree with the issued decision. If the member or member representative chooses to pursue a voluntary second level appeal, they will have the opportunity to appear before the review panel to present member concerns regarding our adverse benefit determination. At this time, an in-person presentation, telephonic conference, video conference or conference via other form of acceptable
technology may be requested and should be noted with the second level appeal request if desired. Written second level appeal requests should be mailed to:

Anthem Blue Cross and Blue Shield
Appeals Department
2 Gannett Drive
South Portland, ME 04106

The member or member representative is responsible for submitting copies of any additional documentation in support of the second level appeal. A second level appeal review will be conducted within 45 business days of receipt of the member’s second level appeal. A written decision will be issued to the member within five (5) working days of completing the review. Determinations include the reason for the decision and provisions of the benefit plan on which the decision was based, as well as information on the next step available for appeal. Once a final decision has been issued by the second level appeal panel, if dissatisfied with the outcome of the voluntary second level appeal, the member may make a written request for external review to the Bureau of Insurance. The Bureau of Insurance will determine eligibility of the appeal for the external review process.

External Review Process

For fully insured health plans the member or member representative, if dissatisfied with the outcome of the first level or voluntary second level appeal, may make a written request for external review to the Bureau of Insurance. The request must be made within 12 months of the date the member received the final adverse health care treatment decision of the first level or voluntary second level appeal.

Clinical Quality Improvement Activities

As a participating provider, you have agreed to cooperate and comply with our quality improvement activities.

AB is committed to improving the quality of clinical care, clinical services, and member services. Several programs have been implemented in an effort to positively affect outcomes.

- **Follow-up after discharge for mental illness**: This program supports the Health Care Effectiveness Data Information Set (HEDIS®) effectiveness of care measure for follow-up visits after hospitalization. All members hospitalized with a psychiatric disorder should have a follow-up visit within seven days of discharge. AB care managers work with participating facilities and practitioners to facilitate that the member has an appointment before he/she is discharged. AB quality staff contacts provider offices and members to verify appointments and ascertain what mechanisms offices utilize to remind patients of scheduled appointments and what policies they have to work with patients regarding missed appointments.

- **Depression education program/antidepressant medication management**: This program supports the HEDIS effectiveness of care measure for antidepressant medication management. Members newly diagnosed with depression should remain on prescribed antidepressant medication for a minimum of six (6) months. In addition, these members should be seen for at least three (3) medication management visits during the acute treatment period (first 12 weeks). We work with the health plan in developing interventions to educate providers and members about the importance of adequate medication management for those members diagnosed with depression and started on antidepressant medication.

- **Bipolar medication compliance**: This program identifies those members, age 18 or older, with a bipolar I diagnosis that have been non-compliant with their bipolar medications. Prescribers of those medications are communicated this information about their patient via a faxed letter. Members diagnosed with bipolar I disorder are mailed educational information about this disorder.

- **Initiation and engagement of alcohol and other drug (AOD) treatment**: This program supports the HEDIS measure for identification and treatment of members with an alcohol or other drug primary or secondary diagnosis. Specifically, this measure focuses on the percentage of adults and adolescents who initiate treatment through either an AOD inpatient admission or outpatient service and an additional AOD outpatient service within 14 days. Engagement of AOD treatment is designed to assess the degree to which the members engage in treatment with two additional AOD services with 30 days of initiation of treatment. We work with the health plan to develop interventions regarding this measure.
Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (ADD): This program supports the HEDIS measure for treatment of children with ADHD. Specifically, this measure focuses on children who have been prescribed an ADHD medication and have one (1) follow-up visit with a practitioner with prescriptive authority within the first 30 days. The maintenance measure is for members to remain on the medication for at least 210 days and have at least two (2) additional follow-up visits with a practitioner within nine months after the initial 30 days. We work with the health plan to develop interventions regarding this measure.

Provider Satisfaction Surveys

At least annually, AB surveys members for their levels of satisfaction with their therapists, AB's services, the care management process, and whether they were able to access care easily. AB matches survey responses to individual providers if indicated. AB reports aggregate results, and tracks individual provider results for evaluation of provider effectiveness.

In addition, at least annually, Anthem surveys physicians and providers, including behavioral health providers, for levels of satisfaction with services pertaining to areas such as utilization management and claims.

SECTION 3
Network Participation

Network Selection

AB is responsible for maintaining a broad spectrum of network services that consists of licensed professionals in psychiatry, clinical psychology, clinical social work, advanced nursing, addiction medicine, clinical professional counselors, marriage and family therapists and other behavioral health disciplines.

Before a provider can begin to treat members, the provider must successfully complete the credentialing and application process and sign an Anthem Participating Provider Agreement. Additionally, successful applicants must:

- Demonstrate expertise in child, adolescent, and/or adult treatment
- Have an excellent community reputation with no history of serious ethical or malpractice complaints
- Have experience with managed care and targeted or focused therapy
- Demonstrate ability to meet required minimum access standards
- Agree to follow AB's policies, procedures, and treatment protocols

All AB participating practitioners must be state licensed and/or certified for independent practice in their discipline. Facilities must be state licensed, and be accredited by a recognized accrediting body such as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or Commission on Accreditation of Rehabilitation Facilities (CARF). Alternative programs that are not eligible for JCAHO or other accreditation must meet Anthem’s participation criteria, if any.

Participating Physician, Provider and Group Agreements

About our Agreements

Your participation with Anthem 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 (as appropriate). To avoid delays in compensation and gaps in participation, it is important that you contact the Plan whenever there is a change in your practice.

- A signed participation agreement between a solo physician/health care professional or provider group and Anthem is applicable to office locations, approved by Anthem and the practitioner or group that renders services to our members under the same tax ID number.
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 the Plan 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 tax ID number 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 may need to be completed and submitted. Please contact AB immediately. This will be needed in order to facilitate accurate payment processing.

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.

**Credentialing Process**

We adhere to credentialing guidelines established by National Committee for Quality Assurance (NCQA) for both practitioners and facilities, as well as for on-site visits. We visit providers expected to treat a high volume of members before a credentialing decision is made by Anthem Credentialing Committee.

The provider represents that the information reported in his/her credentialing application is true and correct. We must be notified within ten (10) days of any changes in the information contained in any credentialing application.

**Professional Practitioner Credentialing**

All network applicants, regardless of practice discipline, submit the following minimum credentials for verification:

- State licensure
- Board certification (if indicated)
- Education and training (at highest level)
- Clinical privileges (at designated primary admitting facility)
- Work history
- Current malpractice insurance
- Malpractice claims history
- DEA or CDS certification
- Medicare/Medicaid sanctions/limitations

All other information on the credentialing application must be completed.
Facility/Program Credentialing

Whether credentialing a facility with one or more programs or an individual organization, the facility is required to submit a completed application with the following attachments:

- JCAHO or CARF certification, if applicable
- Medicare certified, if applicable
- State licenses required for each program
- Adequate malpractice insurance
- Malpractice claims history
- Any sanction activity information
- Facility application sheet
- Any outpatient clinic service must be provided by licensed clinicians as required in the Participating Facility Contract

JCAHO or CARF accreditation is required for all inpatient mental health and substance use facilities.

Recredentialing

- Professional providers are formally recredentialed every three (3) years.
- Facilities are formally recredentialed every three (3) years.

Recredentialing begins six (6) months prior to the expiration of the current credentialing cycle. Providers must submit an updated recredentialing application. All information subject to change is verified according to our credentialing policies.

Providers’ practice profiles, compiled from the preceding three (3) years of network participation are considered during the recredentialing decision-making process.

On-going Monitoring

The credentialing staff has policies and procedures for ongoing monitoring of practitioner sanctions, complaints and quality issues between recredentialing cycles and takes appropriate action against practitioners when it identifies occurrences of poor quality. The Plan takes appropriate interventions by collecting and reviewing Medicare and Medicaid sanctions, sanctions or limitations on licensure, complaints, information from identified adverse events and implementing appropriate interventions when it identifies instances of poor quality, when appropriate.

Provider Sanctions and Termination

We encourage resolution of provider quality issues through consultation and education, but occasionally further action is required to ensure quality service delivery and protection of members. Anthem may impose provider sanctions for issues related to quality of care or contract compliance. Some of the factors used to determine whether to sanction a network provider or terminate network privileges include the following:

- Report of quality of care concerns and critical incidents
- Failure to submit required reports and follow authorization procedures
- Provider’s utilization for inpatient and/or outpatient cases, by diagnoses and acuity level, falls significantly above or below average rates, and such variations are not supported by generally prevailing clinical practice
- Negative results from member satisfaction surveys
- Negative results from quality indicators

Network Termination

Participation may be terminated by any party without cause upon 90 days prior written notice to the other party. Upon such termination, the rights of each party hereunder shall terminate, provided, however, that such action shall not release behavioral health provider from their obligation to complete treatment of persons then receiving treatment.

Termination with Cause

a. Immediate Termination: Anthem may terminate provider from participation in the Anthem network immediately upon written notice for cause. Cause shall include, but is not limited to:
i. Alcohol or drug abuse for which a provider is not receiving professional treatment and complying with the treatment plan (consistent with the provisions of the American with Disabilities Act);

ii. Diagnosis of a mental or physical condition which has resulted or may result in the provider performing his or her duties in a manner which endangers the health or safety of the patients (consistent with the provisions of the American with Disabilities Act);

iii. A final determination of fraud by a government agency or final disciplinary action by a state licensing board or other government agency that impairs the ability of a provider to practice;

iv. Any other case involving imminent harm to patient care.

b. Termination after Notice: Anthem may terminate a provider from participation in the Anthem network for cause after providing sixty (60) days prior written notice and an opportunity for a hearing after the occurrence of any of the following:

i. Repeated failure to comply with quality improvement activities and utilization review activities,

ii. Repeated failure to comply with the terms of this Agreement,

iii. A formal charging (complaint or indictment) for a criminal offense,

iv. Failure to meet credentialing or recredentialing criteria and the absence of a plan acceptable to Anthem or Anthem Subcontractor for meeting those criteria,

v. Unprofessional conduct which may include, but is not limited to, failure to adhere to established standards of medical care.

Rights and Obligations upon Termination

When network participation terminates for any reason, the rights and obligations under the terms of the Participating Provider Agreement terminate, except as expressly provided for in the Agreement or in this Administrative Policies and Procedures Manual.

Members' Rights to Continuing Treatment When Network Participation Ends

When a provider resigns or is terminated for reasons other than quality of care concerns, members may continue a course of treatment in progress which shall be concluded within 90 days. This period is to be used to conclude treatment or transition members to participating providers.

SECTION 4
Provider Responsibilities

- Act in accordance with the terms of the Participating Professional, Group or Facility Agreement.
- Provide services at locations acceptable to AB.
- Notify AB of practice changes at least thirty days in advance.
- Make services available and accessible to members 24 hours per day, seven (7) days per week, and 365 days per year and in a manner that assures continuity of care.
- Meet AB's access standards for emergent, urgent and routine appointments.
- Notify AB immediately of any sanction or limitation on practice or privileges.
- Notify AB of quality of care concerns or critical incidents.
- Adhere to Administrative Policies and Procedures.
- Participate in the Credentialing and Recredentialing Program.
- Follow AB's Care Management procedures.
- Adhere to Member Rights and Responsibilities. (Included in the Member Rights and Responsibilities Section)
- Comply with all State/Federal laws and AB policies protecting patient privacy and handling of confidential treatment information.
- Comply with AB's Quality Improvement activities.
- Distribute member educational materials provided by AB.
- Comply with record standards, reviews, and site visits.

(Please note: This listing is a reference and is not exclusive. Items are described in detail throughout this manual and in your provider agreement.)

**Provider Coverage**

In the event that you use the services of other providers for coverage purposes, covering arrangements must be made with another participating provider except in unusual and unanticipated circumstances when approved in advance by AB. Designated covering providers are subject to credentialing. In all cases, you should arrange with the covering provider that he/she would accept payment from us as payment in full, except for any applicable member cost shares.

**Duty to Warn**

All participating providers must comply with all applicable federal and state reporting requirements. You have an obligation to report and duty to warn, which supersedes the patient’s right to privacy in cases of life-threatening emergency, threat of harm to self or others, or suspected child or elder abuse or neglect. Disclosure of relevant information should be made immediately to appropriate state or local authorities, and any persons at risk.

**Required Reporting**

The provider shall notify us in writing immediately after the occurrence of any of the following:

1. Changes in office or billing address
2. Any actions to restrict, suspend, or revoke the provider's licenses, permits, approvals, accreditations or certifications.
3. Any action to restrict, suspend or revoke any medical staff privileges.
4. Any suit or proceeding brought against the provider for negligence in providing service and the final disposition of such action by settlement or adjudication.
5. Termination, reduction or cancellation of the insurance coverages required by the Participating Provider Agreement.
6. Any criminal action against the provider.
7. Any other situation that might materially affect the provider’s ability to carry out the duties outlined under the Participation Agreement or to meet any credentialing criteria.

**Use of Name**

As a participating provider your name, address, and other relevant practice-related information is included in literature distributed to current and potential members, payers, and fellow participating providers.

**Site Visits**

To promote the provision of care to members in safe, clean, confidential environments, AB conducts selected on-site inspections of providers’ offices. The physical space, appointment scheduling, and record keeping practices are evaluated.

Site visits are conducted at the time of initial credentialing for potential high-volume providers and for participating high-volume providers opening new offices or moving to offices which have never had a site visited.

Expectations are outlined below. Please review these requirements with your office personnel to ensure compliance. Multi-site practices will require visits at each separate location. We will contact selected offices to arrange for a mutually convenient time for each visit. Following the site-visit, you will receive a written finding and report. A detailed corrective action plan may be included to assist you in meeting compliance.

1. Office site is easy to locate
2. Office has adequate parking
3. Office is handicapped accessible
4. On observation, the office appears safe for patients as evidenced by visible fire/smoke detecting devices and/or sprinkler systems that are routinely checked
5. Exits are clearly marked
6. Ample waiting room seating
7. Office has adequate soundproofing to ensure confidentiality
8. Provider has informed consent document and release of information forms
9. Office environment is clean
10. Patient records, prescription pads, medications in a secure area
11. Separate record for each patient that is accessible to the provider
   a. all pages include patient name and/or ID number
   b. all records include demographic information
   c. all entries indicate the clinical provider/practitioner and professional degree
   d. all entries are dated
   e. the record is legible
   f. the record is organized to include prescribed medications (if applicable) and progress notes
12. Appointment availability within standard
13. Procedure for on-call coverage when office is closed

Treatment Record Standards
At our discretion, a treatment record audit may be performed. AB has adopted the minimum documentation standards required. A copy of these standards is attached to this manual (Attachment B). Please review these standards with your office personnel.

SECTION 5
Members’ Rights and Responsibilities

Non-Discrimination Policy
Providers are strictly prohibited from discriminating against members in the provision of services, either in the quality, quantity, or type of services rendered in any other manner, on the basis of race, color, sex, disability, handicap, sexual orientation, age, religion, national origin, ancestry, veteran status, including Vietnam veteran status, place of residence, health status, need for health services or source of payment.

Confidentiality of Patient Records
We all understand the importance of protecting patients’ privacy rights. Federal and state laws govern protecting patient confidentiality, and it is an obligation under your participating provider agreement. We have adopted policies and procedures that ensure confidential handling of all member information. These policies and procedures extend to participating providers. Please review the following procedures with your office personnel to guard against unauthorized or inadvertent disclosure of confidential information:

Confidential information includes member name, address, identification number, medical records including medical history, diagnosis, treatment history, claim information, lab reports, and pharmacy records.

- Member information should be marked as confidential, kept out of view or access to unauthorized individuals, maintained in secured locations under lock and key, and disposed of by shredding. Computers used to store member identifiable information must be password-protected. The monitor must be placed so that the screen is not visible to unauthorized individuals.
- Member information may be disclosed only with a signed release from the member, parent, legal guardian, or estate executor, except in cases of suspected child abuse, danger to self or others, or when law permits disclosure.
Member Rights & Responsibilities

Anthem is committed to developing partnerships with members and participating health care professionals. To further that goal, the Members’ Bill of Rights & Responsibilities will serve as a testimony to that commitment. The Members’ Rights and Responsibilities Statement is adapted from the NCQA Standards for the Accreditation of Managed Healthcare Organizations and is available on our web site at anthem.com.

SECTION 6
Claims Procedures

Participating Provider Payment Policy

Compensation for covered services is at the contracted rate, less amounts of member cost shares payable by the member. Member eligibility and member cost shares may be verified through Provider Services at 800-832-6011. If it is found that a member was not actively covered at the time services were delivered, the member is responsible for all fees, not Anthem.

Members Held Harmless

The Participating Provider Agreement requires that members be held harmless for any incurred charges for services that are covered under the member’s health benefit plan except for coinsurance, co-payment and deductible. The provider may require the member, only if, before delivering such services, the provider, in writing, duly informs the member or person acting on the member’s behalf, to self-pay for services not covered under their health benefit plan or for services not meeting medical necessity criteria.

Patient Balance Billing Prohibited

Balance billing members for amounts above contracted rates is strictly prohibited. Providers may collect applicable deductibles, co-insurance and / or co-payment amounts from the member at the time of service.

Missed Appointment Policy

Providers may charge members for missed appointments only if the provider’s written policy is acknowledged by the member in writing before the start of treatment.

Maximum Visits Per Day

Anthem administered plans only provide benefits for one professional service per day except for the following:

1. Outpatient psychotherapy with a behavioral health non-prescriber professional and medication management with a recognized medication management professional (psychiatrist or psychiatric nurse practitioner) provided on the same day.
2. Outpatient psychotherapy and psychological testing provided on the same day.
3. Comprehensive outpatient services, including group therapy

Please note that account-specific variations may exist. Benefit information can be obtained by calling our Provider Services number.

Secondary Coverage

The Provider must exhaust all other insurance coverage and payment prior to billing Anthem for covered services. When a decision regarding compensation has been made by another insurance carrier, a copy of the disposition of payment or explanation of benefits (EOB) must accompany the appropriate claim form.

The claim for a member with an Anthem Plan as the secondary coverage must be submitted within 365 days of receipt of primary payment.
Incomplete Claims
Claims will be returned due to invalid or incomplete required fields. The provider will be notified via letter outlining the fields requiring completion or correction. The original claim will be returned with the letter. To receive compensation, the provider must resubmit the claim with the fields corrected or completed within the original timely filing limits.

Claim Submission Guidelines
All claims, except the Federal Employee Program (FEP) are processed and paid by Anthem. Please mail all claims to:

Anthem Blue Cross and Blue Shield
PO BOX 533
North Haven, CT 06473

FEP claims should be submitted to:

Anthem Blue Cross and Blue Shield
FEP Maine Claims
PO Box 37980
Louisville, KY 40233-7980

Claims for outpatient/office services must be submitted on the National Industry Standard Claim Form (CMS-1500). The Uniform Billing Form (UB-04) must be used for in-patient institutional services and institutional intensive outpatient programs, crisis visits, partial hospital, etc.

1. A separate claim form must be submitted for each patient containing all of the required elements.
2. Each line item can include no more than one date of service, per line, for the same procedure code.
3. All claims must be submitted in a timely fashion, consistent with the Participating Provider Agreement. Claims that are not submitted within the contracted filing limits may not be considered for compensation.

Please refer to anthem.com for specific claim form instructions.

Electronic Claims Submission Guidelines
Anthem accepts claims electronically. By electronically submitting claims for Anthem members, you can:

• Rely on weekly claims remittances
• Benefit from more accurate and faster claims processing
• Access members’ coverage and eligibility status data
• Reduce the process of posting payments to patient accounts
• Shorten waiting periods between claim submission and remittance and improve overall efficiency

If you wish to inquire about electronic claims submission contact:

EDI Support Unit - 800-334-8262

Coordination of Benefits
All benefits of the contract are subject to coordination of benefits (COB). COB is a formula that determines how benefits are paid to members covered by more than one contract. It helps keep down the cost of health coverage by ensuring that the total benefits a member receives from all contracts do not exceed the cost of covered services.

COB sets the payment responsibilities for any contract that covers the member, such as:
• Group, individual (also known as non-group), self-insured plans, franchise, or blanket insurance, including coverage through a school or other educational institutions but excluding school accident type coverage;
• Group practice, individual practice, and other prepaid group coverage, labor-management trustee plan, union welfare plan, employer organization plan, or employee benefit organization plan; or
• Other insurance that provides medical benefits.

**COB Claim Submission**

The contract with primary responsibility provides full benefits for covered services as if there were no other coverage. The contract with secondary responsibility may provide benefits for covered services in addition to those of the primary contract. When there are more than two contracts covering the person, the contract may be primary to one or more contracts, and may be secondary to another contract or contracts. Payments are limited to the benefit maximums or to the maximum allowance for the services you provide.

**Duplicate Coverage**

- If the other contract does not contain a COB clause or does not allow coordination of benefits with this contract, the benefits of that contract will be primary;
- If both contracts contain a COB clause allowing the coordination of benefits with this contract, we will determine benefit payments by using the first of the following rules that applies:
  1. Non-dependent/dependent: The benefits of the contract that covers the member as an employee or subscriber will be determined before the benefits of the contract that covers the member as a dependent are determined.
  2. Dependent children (parents not legally separated or divorced): For claims on covered dependent children, the contract of the parent whose birthday occurs first in the year will be primary. If both parents have the same birthday, the contract that has covered one parent longer will be primary over the contract that has covered the other parent for a shorter period. If the other contract does not include the rule described immediately above, but instead has a rule based on the gender of the parent, and as a result the contracts do not agree on the order of benefits, the rule in this contract will determine the order of benefits.
  3. Dependent children (parents legally separated or divorced): In the case of legal separation or divorce, the coverage of the parent with custody will be primary. If the parent with custody has remarried, coverage of the parent’s spouse will be secondary, and the coverage of the parent without custody will be last. Whenever a court decree specifies the parent who is financially responsible for the dependent’s health care expenses, the coverage of that parent’s contract will be primary. If a court decree states that the parents have joint custody, without stating that one or the other parent is responsible for the health care expenses of the child, the order of benefits is determined by following rule two.
  4. Active/inactive employee: The benefits of a contract that covers a person as an employee who is neither laid-off nor retired (or as that employee’s dependent) are determined before those of a contract that covers the person as a laid-off or retired employee (or as that employee’s dependent). If the other coverage does not include this provision, and as a result, the contracts do not agree on the order of benefits rule six applies.
  5. Continuation of coverage: If a person whose coverage is provided under the right of continuation pursuant to a federal or state law is also covered by another contract, the benefits of the contract covering the person as an employee or subscriber, or as the dependent of an employee or subscriber, will be primary. The benefits of the continuation coverage will be secondary. If the other contract does not include this provision regarding continuation coverage, rule six applies.
  6. Longer/shorter length of coverage: If none of the rules above determines the order of benefits, the benefits of the contract that has covered the employee or subscriber longer will be determined before those of the contract that has covered the person for a shorter period.
We reserve the right to:

- Take any action needed to carry out the terms of this section;
- Exchange information with an insurance company or other party;
- Recover the Plan’s excess payment from another party or reimburse another party for its excess payment; and
- Take these actions when we decide they’re necessary without notifying the covered persons.

SECTION 7
Attachments

A. CLINICAL TREATMENT RECORD STANDARDS AND AUDIT SUMMARY

B. OUTPATIENT TREATMENT REPORT FORM
# Clinical Treatment Record Standards and Audit Summary

<table>
<thead>
<tr>
<th>#</th>
<th>Standard</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>All pages include patient name and/or ID number.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>All records include demographic data including: name, address, employer or school, phone #s (including home, work and emergency), marital/legal status, appropriate consent forms, and guardianship information, if relevant.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Entries are dated and indicate the responsible clinician’s name, professional degree.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>The record is legible to the auditor.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Medication allergies, adverse reactions, and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Presenting problems, along with relevant psychological and social conditions affecting the patient’s medical and psychiatric status and the results of a mental status exam, are documented.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Prescribed medications are documented including: name of medication, dosage, and dates of initial prescription or refills.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>A DSM-IV diagnosis is documented, consistent with the presenting problems, history, MSE and/or other assessment data.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated time frames for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. The treatment record reflects continuity and coordination of care between the primary practitioner/provider and the Primary Care Physician or specialist, and consultants, ancillary providers, and health care institutions.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Informed consent for medication and the patient’s understanding of the treatment plan are documented.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Total “Yes” items: _____  Total “No” items: _____  Total “N/A” items: _____

Office Use Only:

% “Yes” items: _____  Corrective Action Plan required? (below 80%): Yes____ No____

% “No” items: _____
OUTPATIENT TREATMENT REPORT

INSTRUCTIONS: Please print all information. Fax completed form to 866-613-4246 (ME).

PATIENT
Name _________________________________ ID # _________________________________ DOB _________________________________

PROVIDER Individual and/or Group
Name _________________________________ Tax ID # _________________________________ License # _________________________________ Phone # _________________________________
Address _________________________________ City _________________________________ State _________________________________ ZIP _________________________________ Fax # _________________________________

DSM-IV or ICD-9 DIAGNOSIS numeric + description

<table>
<thead>
<tr>
<th>Axis I</th>
<th>Axis II</th>
<th>Axis III</th>
<th>Axis IV</th>
<th>Axis V</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MEDICAL CONDITIONS

- [ ] None
- [ ] Chronic Pain
- [ ] Asthma/COPD
- [ ] Dementia
- [ ] Cancer
- [ ] Diabetes
- [ ] Cardiovascular Problems
- [ ] Obesity
- [ ] Other

CURRENT RISK ASSESSMENT

- [ ] Suicidal
  - [ ] Ideation
  - [ ] Plan
  - [ ] Intent
  - [ ] Hx of harming self
- [ ] N/A
- [ ] Suicidal
  - [ ] Ideation
  - [ ] Plan
  - [ ] Intent
  - [ ] Hx of harming others
- [ ] N/A

MEDICATIONS

<table>
<thead>
<tr>
<th>Medication</th>
<th>Psychotropic</th>
<th>Medical</th>
<th>Prescribing MD</th>
<th>PCP</th>
<th>Psychiatrist</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If affective or psychotic disorder is present and no medications are prescribed, please explain:

COORDINATION OF CARE

I have communicated with patient's

- [ ] PCP
- [ ] Specialist
- [ ] Psychiatrist
- [ ] Therapist

TREATMENT HISTORY

- [ ] Inpatient: Within past yr
- [ ] 1 to 3 yrs ago
- [ ] More than 3 yrs ago
- [ ] Outpatient: Within past yr
- [ ] 1 to 3 yrs ago
- [ ] More than 3 yrs ago

SYMPTOMS and FUNCTIONAL IMPAIRMENT

If present, check degree (°)

- [ ] Anxiety
- [ ] Decreased Energy
- [ ] Delusions
- [ ] Depressed Mood
- [ ] Hallucinations
- [ ] Hyperactivity
- [ ] Substance Abuse/Dependence

On Disability:
- [ ] Yes
- [ ] No

Mild  Mod.  Severe

<table>
<thead>
<tr>
<th>Anxiety</th>
<th>Hopelessness</th>
<th>ADLS</th>
<th>Family/Relationships</th>
<th>Inattention</th>
<th>Irritability/Mood instability</th>
<th>Impulsivity</th>
<th>Work/School</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If Substance Abuse is current or focus of treatment, complete the information below:

- [ ] Alcohol
- [ ] Marijuana
- [ ] Heroin
- [ ] Opioids
- [ ] Cocaine
- [ ] Methamphetamine
- [ ] Prescrip. Drugs
- [ ] Inhalants

If Yes, frequency of attendance:

If Yes, is there a sponsor?

DESIRED OBSERVABLE OUTCOMES

Patient agrees with treatment goals
- [ ] Yes
- [ ] No

PROVIDER’S CONTINUED TREATMENT PLAN

<table>
<thead>
<tr>
<th>Modality and CPT Code</th>
<th>Frequency</th>
<th>Anticipated Completion</th>
<th>Level of improvement to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual 90804</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Individual 90805</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Individual 90806</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Ind. w/ Med. Mgmt. 90807</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Couple/Family 90847</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Group 90853</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Medication Mgmt 90862</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
<tr>
<td>Other</td>
<td>___ x per</td>
<td>___ wk</td>
<td>___ mo</td>
</tr>
</tbody>
</table>

TREATMENT PROGRESS

- [ ] Minor
- [ ] Moderate
- [ ] Major

- [ ] No progress to date
- [ ] Maintenance tx of chronic condition

# of sessions provided to date

Start date for new authorization

My signature confirms that I am providing the requested services.

PROVIDER’S SIGNATURE _________________________________ DATE _________________________________

FAX to: 866-613-4246 (ME)  Anthem UM Services, PO BOX 892, North Haven, CT 06473  1-800-755-0851

Rev 052209