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Purpose and Introduction

This provider manual will present a general overview of information regarding key administrative areas; including but not limited to the quality improvement program, the utilization management program, quality standards for Facility and Provider participation, reimbursement and administration policies and provider appeals.

Anthem Blue Cross and Blue Shield in Ohio ("Anthem") is committed to providing Providers and Facilities with an accurate and up to date manual; however, there may be instances where new procedures or processes are not immediately reflected in the manual. In such cases, Anthem will make every effort to provide updated documentation in the next manual update. In those instances where Anthem determines that information in the manual conflicts with the Agreement, the Agreement will take precedence over the manual.

This Manual is intended to support all entities and individuals that have contracted with Anthem. The use of "Provider" within this manual refers to entities and individuals contracted with Anthem that bill on a CMS 1500. They may also be referred to as Professional Providers in some instances. The use of "Facility" within this manual refers to entities contracted with Anthem that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers. General references to “Provider Inquiry”, “Provider Website”, “Provider Network Manager” and similar terms apply to both Providers and Facilities.

Information Sources

- **Anthem Web site** – An internet site available to Anthem BlueCross and BlueShield ("Anthem") Providers and Facilities at www.Anthem.com. The site provides information on:
  - Anthem products
  - Contact phone numbers
  - Provider services
  - Health information
  - Provider directories
  - Network eUpdates

- **Network Update/ Provider Newsletter** – A periodic newsletter publication designed to educate physicians, facilities and hospitals and their appropriate staff on administrative issues, which may contain notice of material changes to contract.

Capitalized terminology in this document is defined in your Anthem Facility Agreement or Anthem Provider Agreement otherwise referred to in this manual as “Agreement”. The provisions of the provider manual apply unless otherwise provided for in your Agreement.
Legal and Administrative Requirements Overview

Appointment Access and Geographic Availability

Anthem uses these standards to assess the care, services and satisfaction of our Ohio Commercial and Healthcare Exchange Covered Individuals. Offices are expected to provide care in accordance with the Covered Individual’s needs and expectations for their medical and behavioral health circumstances.

<table>
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<tr>
<th>MEDICAL APPOINTMENT ACCESS</th>
<th>COMPLIANCE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency</strong></td>
<td>Immediate access 24/7/365 or refer to ER or 911.</td>
</tr>
<tr>
<td><strong>Urgent / Acute Care</strong></td>
<td>Patient can be seen in the office by their doctor, covering doctor or another practitioner in the practice within the timeframe. Patient is directed to Urgent Care Center, 911, or ER or, as appropriate.</td>
</tr>
<tr>
<td><strong>Non-Urgent (Symptomatic or chronic)</strong></td>
<td>Within 72 hours – Patient can be seen in the office by their doctor, covering doctor or another practitioner in the practice within the timeframe.</td>
</tr>
<tr>
<td><strong>Routine / Check-up</strong></td>
<td>Within 10 business days – Patient can be seen in the office by their doctor, covering doctor or another practitioner in the practice within the timeframe.</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>Within 30 calendar days – Patient can be seen in the office by their doctor, covering doctor or another practitioner in the practice within the timeframe.</td>
</tr>
<tr>
<td><strong>Office Wait Time</strong></td>
<td>Recommended not to exceed 30 minutes or less before taken to the exam room.</td>
</tr>
<tr>
<td><strong>After Hours Urgent Care</strong></td>
<td>24/7/365 phone access All Covered Individuals shall have phone access to urgent medical help or instructions after regular business hours through their primary care physicians 24/7 via: Live person connects the caller to their available doctor or on-call doctor. Recording or live person directs the patient to Urgent Care, 911, or ER as appropriate. Additionally, but not in place of above the caller may be directed to contact a live healthcare professional (via cell phone, pager, beeper, transfer system) or to get a call back for urgent instructions. <strong>Having no provision is non-compliant.</strong></td>
</tr>
<tr>
<td>BEHAVIORAL HEALTH APPOINTMENT ACCESS</td>
<td>COMPLIANCE</td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>Emergency</strong></td>
<td>Immediate access 24/7/365 or refer to 911, - ER, or crisis center.</td>
</tr>
</tbody>
</table>
| **Discharge Follow-up BH Appointment** | **Within 7 days**  
*New or existing* patient can be seen in the office by designated BH practitioner within the timeframe after discharge from inpatient psychiatric hospitalization. |
| **Emergent - Non-Life Threatening** | **Within 6 hours**  
- Patient can be seen in the office by their BH practitioner or another participating practitioner in the practice or a covering practitioner within the timeframe  
Patient is directed to 24 hour crisis services, 911 or ER, as appropriate. |
| **Urgent Care**                    | **Within 48 hours**  
- Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe.  
Patient is directed to 24 hour crisis services, 911 or ER, as appropriate. |
| **Routine - Initial Appointment**   | **Within 10 business days**  
*New* patient can be seen in the office by a designated BH practitioner or another appropriate participating practitioner within the timeframe.  
(After the intake assessment or referral.) |
| **Routine - Follow-up Appointment** | **Within 30 calendar days**  
*New or existing* patient can be seen in the office by their BH practitioner, another participating practitioner in the practice or a covering practitioner within the timeframe. |
| **After Hours Urgent Care**         | **24/7/365 phone access**  
All Covered Individual shall have phone access to emergent/urgent instruction/consultation after regular business hours through their BH practitioner via  
- Recording or live person directs patient to 24 hour crisis services, 911 or ER, as appropriate.  
- Caller is directed to contact a BH practitioner (via cell, pager, beeper, transfer system) or get a call back for instructions or consultation.  
*Having no provision is non-compliant.* |
| **Out of Office Coverage**          | Arrangement for coverage when you are unavailable (vacation, illness, holiday, etc.) via:  
- Cell phone, pager, etc.  
- Patient is directed to another BH practitioner in the practice, on call or covering practitioner.  
- Prior arrangement with patients. |

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## MEDICAL NETWORK ADEQUACY

### OPEN PRACTICE

**Note:** Keep Anthem updated on open status.

| | At least 90% of Primary Care Physician's practices will be open for new patient selection. |

### GEOGRAPHIC AVAILABILITY OF MEDICAL PROVIDERS

Mileage is based upon member and provider zip code coordinates and locality definitions per GeoAccess® software.

<table>
<thead>
<tr>
<th>MEDICAL GEOGRAPHICS</th>
<th>MEASURE</th>
</tr>
</thead>
</table>
| **Primary Care Physicians:** Family Medicine, Internal Medicine and Pediatrics | Two of each type within 5 miles (urban)  
Two of each type within 12 miles (suburban)  
Two of each type within 30 miles (rural) |
| **OB/Gyn** | One within 15 miles (urban)  
One within 30 miles (suburban)  
One within 40 miles (rural) |
| **Specialists** | Minimum of one of each major specialty within 30 miles |
| **Hospitals** | One within 30 miles |
| **Skilled Nursing Facility** | One within 30 miles |

## MEDICAL GEOGRAPHICS

### MEASURE

- **Primary Care Physicians:** Family Medicine, Internal Medicine and Pediatrics
  - Two of each type within 5 miles (urban)
  - Two of each type within 12 miles (suburban)
  - Two of each type within 30 miles (rural)

- **OB/Gyn**
  - One within 15 miles (urban)
  - One within 30 miles (suburban)
  - One within 40 miles (rural)

- **Specialists**
  - Minimum of one of each major specialty within 30 miles

- **Hospitals**
  - One within 30 miles

- **Skilled Nursing Facility**
  - One within 30 miles

## MEDICAL GEOGRAPHICS

### MEASURE

- **Psychiatrist (MD/DO)**
  - One within 15 miles (urban)
  - One within 30 miles (suburban)
  - One within 75 miles (rural)

- **Non-MD Professionals:**
  - Psychologist and Masters Level
    - Include Sub-Abuse
    - One of each type within 15 miles (urban)
    - One of each type within 30 miles (suburban)
    - One of each type within 75 miles (rural)

- **BH Treatment Facilities**
  - Facilities offering IP BH services
    - One within 35 miles (urban/suburban combined)
    - One within 75 miles (rural)

## GEOGRAPHIC AVAILABILITY OF BEHAVIORAL HEALTH PROVIDERS

Mileage is based upon member and provider coordinates and locality definitions per GeoAccess® software.

<table>
<thead>
<tr>
<th>BH GEOGRAPHICS</th>
<th>MEASURE</th>
</tr>
</thead>
</table>
| **Psychiatrist (MD/DO)**
  - Include Sub-Abuse | One within 15 miles (urban)  
One within 30 miles (suburban)  
One within 75 miles (rural) |
| **Non-MD Professionals:**
  - Psychologist and Masters Level
    - Include Sub-Abuse | One of each type within 15 miles (urban)  
One of each type within 30 miles (suburban)  
One of each type within 75 miles (rural) |
| **BH Treatment Facilities**
  - Facilities offering IP BH services | One within 35 miles (urban/suburban combined)  
One within 75 miles (rural) |

## CULTURAL DIVERSITY

Practitioners meeting the needs and preferences of their patients

- Doctors are expected to identify their patient’s needs by explaining things in a way they can understand, listen carefully, show respect for what they have to say and spend enough time with the patient.

- Anthem has provided offices with a tool (link below) that provides ideas, resources and tools that can help doctors and their staffs better understand and communicate with select patient groups with specific needs. This allows for patients to fully understand their medical situation and get the maximum benefit from their time with their doctor.

- This Toolkit for Caring for Diverse Populations is organized into several sections. Each contains background information and tools that can be printed for use in the office. http://bridginghealthcaregaps.com
Practitioners can provide Anthem with their gender and race/ethnicity for the provider directory via the Provider Maintenance Form (PMF) at anthem.com. Select Menu, and then under the Support heading select the Providers link. Select [state] from the drop down box and enter. Choose Answers@Anthem, [Provider Maintenance Form and go to Section C.

This information will be utilized in online provider directories available to your customers to locate a doctor who meets their cultural, racial, ethnic, gender and language needs and preferences. Rev 1/2014

Dispute Resolution and Arbitration

Please note in the instances where the information in this section conflicts with the Agreement the Agreement will take precedence.

The substantive rights and obligations of Anthem, Providers and Facilities with respect to resolving disputes are set forth in the Anthem Provider Agreement (the "Agreement") or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Attorney's Fees and Costs

The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator, etc.) will be shared equally between the parties. Each party shall be responsible for the payment of that party's specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.).

Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

B. Location of the Arbitration

The arbitration hearing will be held in the city and state in which the Anthem office identified in the address block on the signature page to the Agreement, is located except that if there is no address block on the signature page, then the arbitration hearing will be held in the city and state in which the Anthem Plan has its principal place of business. Notwithstanding the foregoing, both parties can agree in writing to hold the arbitration hearing in some other location.

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or attorney's fees) the dollar threshold set forth in the Dispute Resolution and Arbitration Article of the Agreement the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. If the arbitrators selected by Provider or Facility and Anthem cannot agree in thirty (30) days on who will serve as the independent arbitrator, then the arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

The parties recognize that litigation in state and federal courts is costly and burdensome. One of the parties' goals in providing for disputes to be arbitrated instead of litigated is to reduce the costs and burdens associated with resolving disputes. Accordingly, the parties expressly agree that discovery shall be conducted with strict adherence to the rules and procedures established by the mediation or arbitration administrator identified in the Dispute Resolution and Arbitration Article of the Agreement, except that the parties will be entitled to serve requests for production of documents and data, which shall be governed by Federal Rules of Civil Procedure 26 and 34.
E. Decision of Arbitrator(s)

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of the Agreement and shall be bound by and follow controlling law, including, but not limited to, any applicable statute of limitations, which shall not be tolled or modified by the Agreement. If there is a dispute regarding the applicability or enforcement of the class waiver provisions found in the Dispute Resolution and Arbitration Article, that dispute shall only be decided by a court of competent jurisdiction and shall not be decided by the arbitrator(s). Either party may request a reasoned award or decision, and if either party makes such a request, the arbitrator(s) shall issue a reasoned award or decision setting forth the factual and legal basis for the decision.

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56. Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

A decision that has been appealed shall not be enforceable while the appeal is pending.

F. Confidentiality

Subject to any disclosures that may be required or requested under state or federal law, all statements made, materials generated or exchanged, and conduct occurring during the arbitration process, including but not limited to materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration. If either party files an action in federal or state court arising from or relating to a mediation or arbitration, all documents must be filed under seal to ensure that confidentiality is maintained. Nothing in this provision, however, shall preclude Anthem or its parent company from disclosing any such details regarding the arbitration to its accountants, auditors, brokers, insurers, reinsurers or retrocessionaires.

Insurance Requirements

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

1. Professional liability/medical malpractice liability insurance which limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers and Facilities shall maintain coverage with limits of not less than the statutory cap. If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agrees to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.

2. Workers' Compensation coverage with statutory limits and Employers Liability insurance

3. Commercial general liability insurance for Providers and Facilities for bodily injury and property damage, including personal injury and contractual liability coverage.

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

- Auto Liability insurance which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render services.
For Air Ambulance Providers Only, in addition to the above:

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

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

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

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

Misrouted Protected Health Information (PHI)

Providers and Facilities are required to review all Covered Individual information received from Anthem to ensure no misrouted PHI is included. Misrouted PHI includes information about Covered Individuals that a Provider or Facility is not currently treating. PHI can be misrouted to Providers and Facilities by mail, fax, email, or electronic remittance. Providers and Facilities are required to immediately destroy any misrouted PHI or safeguard the PHI for as long as it is retained. In no event are Providers or Facilities permitted to misuse or re-disclose misrouted PHI. If Providers or Facilities cannot destroy or safeguard misrouted PHI, Providers and Facilities must contact Provider Services to report receipt of misrouted PHI.

Open Practice

Providers shall give Plan sixty (60) days prior written notice when Provider no longer accepts new patients.

Privacy Policy Statement

Information regarding Anthem’s Corporate Privacy Policy Statement that sets forth guidelines regarding a Covered Individual’s right to access and amend information in Anthem’s possession is available by selecting the “Privacy Statement” at the bottom of the Provider Landing page of our public provider website. To access this information go to www.anthem.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list, and press Enter. Select the Provider Home tab at the top of the page. On the Provider Landing page, scroll to the bottom and click on the “Privacy Statement” link.

Provider and Facility Responsibilities

Providers are required to comply with Federal and State Laws. In addition, providers must verify their employees, contractors, subcontractors or agents have not been identified as ineligible persons on the General Services Administration’ List of Parties Excluded from Federal Programs and the HHS/OIG list of Excluded Individual/Entities or as otherwise designated by the Federal government.

Providers are responsible for notifying Anthem when changes occur within the Provider Organization. Our Provider Agreement requires Providers give Anthem at least 30 days prior notice when making changes. All changes must be approved by Anthem.

Examples of these changes include, but are not limited to:
- adding a new practitioner to your group
- change in ownership
- change in Tax Identification Number
- making changes to your demographic information or adding new locations
- selling or transferring control to any third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business or corporation

Referring to Non-Participating Providers

Anthem’s mission is to provide affordable quality health care benefits to its Covered Individuals. To maximize the value of our Covered Individual’s benefit plans, it is imperative that Covered Individuals access their highest level of health care benefits from Network/Participating Providers and Facilities. Providers and Facilities put Covered Individuals at risk of higher out of pocket expenses when they refer to non-participating providers. To help manage cost, Anthem has in place a non-participating provider Claims payment policy; however, that policy cannot prohibit non-participating providers from billing Covered Individuals the difference between the amount they charge for the service and the amount paid to that non-participating provider.

Providers are reminded that per their Agreement with Anthem they are generally required to refer Covered Individuals to Network/Participating Providers. Providers and Facilities who establish a pattern of referring Covered Individuals to non-participating providers are subject to disciplinary action, up to and including termination from the Network. We understand that there may be instances in which a Network/Participating Provider must refer to a non-participating provider. For additional information on the Non-Participating Provider Claims Payment Policy please refer to the reimbursement policy section of this manual.

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements Medical records and other health and enrollment information of Covered Individuals must be handled under established procedures that:

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

In addition to the obligation to safeguard the privacy of any information that identifies a Covered Individual, Anthem, Providers and Facilities are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

Encounter Data for Risk Adjustment Purposes

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services ("HHS") to adjust the payment made to the health plans under the Affordable Care Act ("ACA") based on the health status of the Covered Individuals who are insured under small group or individual health benefit plans compliant with the ACA (aka "ACA Compliant Plans"). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Covered Individuals by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as a qualifying health plan, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit “all ICD10 codes for each beneficiary”, Anthem also collects diagnosis data from the Covered Individuals’ medical records created and maintained by the Provider or Facility.

Under the HHS risk adjustment model, the health plan is permitted to submit diagnosis data from inpatient hospital, outpatient hospital and physician/qualified non-physician e.g. nurse practitioner encounters only.

Maintaining documentation of Covered Individuals’ visits and of Covered Individuals’ diagnoses and chronic conditions helps Anthem fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or “3Rs” provision in the ACA. To ensure that Anthem is reporting current and accurate Covered Individual diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Covered Individuals insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. Anthem’s goal is to have this information confirmed and/or updated no less than annually. As a condition of the Facility or Provider’s Agreement with Anthem, the Provider or Facility shall comply with Anthem’s requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to Anthem, Plan or designee upon request.

In addition to the above ACA related commercial risk adjustment requirements, Providers and Facilities also may be required to produce certain documentation for Covered Individuals enrolled in Medicare Advantage or Medicaid.
RADV Audits

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

ICD-10 CM Codes

HHS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices for services under ACA Compliant Plans. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider or Facility. For example, in accordance with the guidelines, it is important for Providers and Facilities to code all conditions that co-exist at the time of an encounter and that require or affect patient care, treatment or management. In addition, coding guidelines require that the Provider or Facility code to the highest level of specificity which includes fully documenting the patient’s diagnosis.

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

HHS record documentation requirements include:

- Patient’s name and date of birth should appear on all pages of record.
- Patient’s condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT) or there is evidence of treatment, assessment, monitoring or medicate, plan, evaluate, referral (TAMPER).
- The documentation describing the condition and MEAT or TAMPER must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician’s/Qualified Non-Physician’s signature, credentials and date must appear on record and must be legible.
Directory of Services

Provider Services, Network Relations and Contracting

In order to meet the service needs of our Providers and Facilities, we have assembled an experienced staff consisting of Provider Service Representatives, Provider Network Managers and Network Relation Consultants available to assist you. They have access to email and voicemail in the event that you are not able to reach them by telephone.

Contact a Provider Service Representative by calling the Provider Inquiry Department at (800) 282-1016 or the phone number provided on the back of the Covered Individual's identification card (“ID”) for questions/comments concerning:

- Claims status
- Eligibility Claims reviews
- Complaints
- Claims coding and or submission

The Network Relations Consultants generally serve as a liaison and are responsible for on-site orientation, ongoing training and policy/procedure consultation. They will assist you with administrative policy and procedure problem resolution and service needs. They have access to email and voicemail in the event that you are not able to reach them by telephone.

Providers and Facilities can obtain a listing of the Network Relations Offices by going to www.anthem.com.

- select provider
- select Ohio
- select Communications
- select Important Phone Numbers

The Provider Network Managers generally serve as the primary contacts for Network contracting.

Provider Directory

The provider directory is available on our website at www.anthem.com. If you do not have internet access contact the Provider Inquiry Department for assistance in identifying Network Providers and Facilities.

Providers using the directory for referrals to in-network providers should note that not all providers are contracted for all Anthem networks.

Anthem Provider Web Site

www.Anthem.com

Anthem.com is the unsecured section of the web portal.

The public provider website holds timely and important information to assist providers when working with Anthem. Some items that can be located from the Provider Home Page include:

- Self Service and Support
  - Medical Policies and Clinical UM Guidelines
  - Behavioral Health Provider Resources
  - Electronic Data Interchange (EDI)
  - Electronic Self-Service Options
  - Precertification (Tools)
  - Precertification Guidelines
  - Provider Maintenance Form
Our Plans & Benefits
Health and Wellness
Communications & Updates
  o Health Care Reform and Notifications
  o ICD-10
  o Network eUPDATE (formerly Rapid Update)
  o Network Update (Provider Newsletter)
Important Updates
Link to sign up for Anthem’s Network eUPDATE (formerly Rapid Update)
Contact Us

MyAnthem
In order to streamline the user experience, effective May 13, 2016, providers now go exclusively to the Availity Web Portal to access Remittance Inquiry, Fee Schedule Inquiry and Reports. Access this information by Selecting Payer Spaces, Anthem and then select the functionality you’re interested in. If you do not see this functionality, please contact the Availity Access Administrator for your organization to have your user role updated.

Information and documentation currently available on MyAnthem is viewable by any Availity Web Portal user with access to the states of Indiana, Ohio, Kentucky, Missouri or Wisconsin by navigating to the “More” menu and selecting Provider Portal (Anthem) under My Payer Portals. NOTE: This content will be available directly on Availity Web Portal in the future. Please watch for communication updates.

Availity Web Portal
Anthem is offering an array of online tools through the Availity® Web Portal, a secure multi-health plan portal. Get the information you need instantly
  • Member eligibility and benefits inquiry – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL members, including BlueCard® and FEP.
  • Claim status inquiry – See details and payment information including claim line-level details/processing.
  • Claim submission – submit a single electronic claim
  • Remit Inquiry – View an imaged copy of the paper Anthem remits up to 15 months in the past
  • Fee Schedule - Retrieves professional contracted price information for patient services performed
  • Patient360 – Real time, robust picture of your patient’s health and treatment history
  • Care Reminders – Receive clinical alerts on members’ care gaps and medication compliance indicators, when available.
  • Secure Messaging* – Send a question to clarify the status of a claim or to get additional information on claims.
  • AIM Specialty HealthSM (AIM) – link to precertification requests and inquiries through AIM.
  • OptiNet Survey on AIM – link to the survey via AIM Specialty Health
  • Member Certificate Booklet – View a local plan member’s certificate of coverage, when available.
  • Interactive Care Reviewer – Secure, online provider precertification, referral and inquiry tool.

* Anthem-specific products that can be accessed through Availity require continued registration on MyAnthemSM.
Take advantage of these Availity benefits
- **No charge** – Anthem transactions are available at no charge to providers.
- **Accessibility** – Availity functions are available 24 hours a day from any computer with Internet access.
- **Standard responses** – Responses from multiple payers returned in the same format and screen layout providing users with a consistent look and feel.
- **Access to both commercial and government payers** – Users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See [www.availity.com](http://www.availity.com) for a full list of payers.)
- **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

How to get started
To register for access to Availity, go to [www.availity.com/providers/registration-details/](http://www.availity.com/providers/registration-details/). It's that simple!

Once you log into the Web Portal, you'll have access to many resources to help jumpstart your learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure you get the most out of your Availity Web Portal experience. To view the current training resources, select Help and “Get Trained” from the main page of the Availity Web Portal. Client service representatives are also available Monday through Friday to answer your questions at 800-AVAILITY (800-282-4548).

Availity services and coverage are always expanding. Please check frequently for new offerings.

**E-Review**
E-Review is a web based tool that allows providers, clinics, and facilities to communicate their requests for services via a secured HIPAA compliant email to and from the associates of the Medical Management departments of Anthem.

E-review can be used for:
- Precertification and Concurrent Review
- Predeterminations
- Retrospective Review
- Behavioral Health Review

For more information, click on the Precertification link under Self-Service and Support on the Provider Home page, or contact your local Network Relations Consultant

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**Claims Submission**

**Service Area**

The service area for Anthem in Ohio contains the following counties:

**Northern Ohio: Ohio counties:** Ashtabula, Belmont, Carroll, Columbiana, Cuyahoga, Defiance, Erie, Fulton, Geauga, Harrison, Henry, Holmes, Huron, Jefferson, Lake, Lorain, Lucas, Mahoning, Medina, Ottawa, Portage, Sandusky, Seneca, Stark, Summit, Trumbull; Tuscarawas, Wayne, Williams, Wood; **Michigan Counties:** Hillsdale; Lenawee; Monroe. **Pennsylvania Counties:** Beaver; Crawford; Erie, Lawrence; Mercer. **West Virginia Counties:** Brooke, Hancock, Marshall, Ohio.

**Central Ohio: Ohio counties:** Ashland, Athens, Coshocton, Crawford, Delaware, Fairfield, Fayette, Franklin, Gallia, Guernsey, Hardin, Hocking, Jackson, Knox, Lawrence, Licking, Madison, Marion, Meigs, Monroe, Morgan, Morrow, Muskingum, Noble, Perry, Pickaway, Pike, Richland, Ross, Scioto, Union, Vinton, Washington, Wyandot; **West Virginia counties:** Pleasants, Tyler, Wetzel, Wood.

**Southern Ohio: Ohio counties:** Adams, Allen, Auglaize, Brown, Butler, Champaign, Clark, Clermont, Clinton, Darke, Greene, Hamilton, Hancock, Highland, Logan, Mercer, Miami, Montgomery, Paulding, Preble, Putnam, Shelby, Van Wert, Warren; **Kentucky counties:** Boone, Campbell, Gallatin, Grant, Kenton, Pendleton.
Claim Filing Tips
Eliminate processing delays and unnecessary correspondence with these claim filing tips.

Please submit your claims electronically whenever possible. If you have questions about electronic submissions, or if you want to learn more about how EDI can work for you, please review the EDI Submissions section in this manual or call 1-800-470-9630.

If you must file your claims on paper, failure to submit them on the most current CMS-1500 (Form 1500 (02-12)) or CMS-1450 (UB04) will cause your claim to be rejected and returned to you. More information and the most current forms can be found at www.cms.gov.

- Submit all paper claims using the current standard RED CMS Form-1500 (02-12) for professional claims and the UB-04 (CMS-1450) for Facility claims.
- If you are submitting a multiple page claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields on the claim form.
- Do not highlight any fields.
- Check the printing of your claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid member identification number including three digit alpha-prefix or R+8 numeric for Federal Employee Program (FEP®) members on all pages of the CMS Form 1500 (02-12) claim form.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages of the claim form.
- Do not include “negative” charges or your claim will be returned.
- Pharmacies should use CPT code A4253 when billing diabetic test strips
- Field 43 must be used when submitting a description on a CMS-1450 (UB-04) claim form.
- When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare’s Assignment.
- When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

The following types of claims may require additional information to avoid delays. Please contact your service area’s Provider Service department for details on additional records required.

<table>
<thead>
<tr>
<th>Type of Care/Claim</th>
<th>Records Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>BiPap</td>
<td>- History &amp; Physical (“H&amp;P”)</td>
</tr>
<tr>
<td></td>
<td>- Office notes</td>
</tr>
<tr>
<td></td>
<td>- Sleep study results</td>
</tr>
<tr>
<td></td>
<td>- Prescription for BiPap</td>
</tr>
<tr>
<td></td>
<td>- Documentation of failed CPAP trial</td>
</tr>
<tr>
<td>Procedure</td>
<td>Required Documentation</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>----------------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| Breast Reduction                | - Recent H & P and initial evaluation  
                                | - Office notes  
                                | - Documentation of all previous conservative treatment  
                                | - Operative report indicating amount of tissue removed from each breast  
                                | - Pathology report  
                                | - Presenting symptoms and their duration  
                                | - Covered Individual’s height and weight – Body Mass Index (“BMI”)  
                                | - Do not send photos unless specifically requested by Anthem |
| Cardiac Rehab                   | - Start of care date for the cardiac rehab program  
                                | - Daily breakdown of charges  
                                | - Date of onset and nature of recent cardiac event  
                                | - All therapy records  
                                | - Supporting documentation why program exceeded the 12-week/36-session limit if applicable |
| DME                             | - Recent H & P and initial evaluation  
                                | - Office notes  
                                | - MD order  
                                | - Therapy and progress notes  
                                | - Manufacturer’s description and model number |
| Growth Hormone                  | - Recent H & P and initial evaluation  
                                | - Office notes  
                                | - Therapy and progress notes  
                                | - Treatment protocol  
                                | - Growth hormone (“GH”) stimulator tests results  
                                | - Recent X-ray report (not films) that shows status of epiphyses  
                                | - Recent growth chart including documented percentile of height for age including number of standard deviations below the mean |
| Not Otherwise Classified (“NOC”) code NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service | - Complete, specific description of procedure/service/Durable Medical Equipment (“DME”)/drug  
                                | - Manufacture’s description and model number for DME  
                                | - If the item is a rental item, include the purchase price.  
                                | - If the NOC is for a drug, include the drug’s name, dosage NDC number and number of units.  
                                | - If NOC code is for a surgical procedure, include the operative report.  
                                | - Medical records to support the changes for the NOC code including documentation to support medical necessity of the item or service  
                                | - If NOC is for an office procedure, include office notes for the date of service for which the NOC code was billed. |
| Sclerotherapy or treatment of varicose veins | - Recent H & P and initial evaluation  
                                | - Office notes  
                                | - Documentation of all previous conservative treatments, including length of treatments tried  
                                | - Doppler study result  
                                | - Complete, specific description of surgical procedure performed |
| Synagis                         | - Recent H & P and initial evaluation  
                                | - Office notes  
                                | - Gestational age at birth  
                                | - Documentation of all specific risk factors present |

**Recommended Fields for CMS Form 1500 (02-12)**

If these are not completed, your claim may be delayed or returned to you for additional information.

Field 1a: Insured’s ID Number – from Covered Individual ID card, including any alpha prefix

Field 2: Patient’s Name – do not use nicknames or middle names.

Field 3: Patient’s Birth Date – date of birth should be mmddccyy format and Sex

Field 4: Insured’s Name – “same” is acceptable if the insured is the patient.

Field 5: Patient’s Address – submitted when the patient’s address is different than the insured’s address. If it’s the same, this field does not need to be populated.
Field 6: Patient Relationship to Insured

Field 7: Insured's Address

Field 10: Is Patient's Condition Related to:

Field 10A: Employment?

Field 10B: Auto Accident? Field

10C: Other Accident?

Field 12: Patient Authorization Signature – If patient signature is on file, “Signature on file” is acceptable

Important information about Fields 14 and 15:
CMS Form 1500 (02-12) gives providers two fields (14 and 15) to enter a date with a “Qualifier” that tells payers what the date is for. Field 14 is titled “Date of Current Illness, Injury, or Pregnancy” and field 15 is titled “Other Date”. If the visit is due to an accident, Qualifier “439” must be entered in field 15 along with the appropriate date. This information is consistent with the form instruction manual available on the NUCC website. For more guidance, please see information the available on the NUCC website at www.nucc.org.

Field 14: Date of Current – illness, injury or pregnancy (LMP) (if applicable) – Enter the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported:
- 431 – Onset of current symptoms or illness
- 484 – Last Menstrual Period

Field 15: Other Date – Enter another date related to the patient's condition or treatment. Enter the date in the 6-digit (MM|DD|YY) or 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:
- 454 – Initial treatment
- 304 – Latest visit or consultation
- 453 – Acute manifestation or a chronic condition
- 439 – Accident
- 455 – Last X-ray
- 471 – Prescription
- 090 – Report start (assumed care date)
- 091 – Report end (relinquished care date)
- 444 – First visit or consultation

Field 16: Dates Patient Unable to Work in Current Occupation – This is the time span a patient is or was unable to work

Field 17: Referring physician name – Enter the name of the referring or ordering provider. Enter the applicable qualifier to the left of the vertical, dotted line:
- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising provider

Field 17b: Referring physician NPI

Field 21: Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature – Relate A-L (change from numeric to alpha characters) to Field 24E

Field 21: ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or claim may be rejected. Enter “9” for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or “0” for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later.
Field 22: Resubmission and/or Original Reference Number – This field is not intended for original claim submissions. When resubmitting a claim, enter the original Anthem claim number and the appropriate bill frequency code (7=Replacement of prior claim; 8=Void/Cancel of prior claim) left justified in the left-hand side of the field.

Field 23: Attention Ambulance Providers: Consistent with guidance from the Centers for Medicare and Medicaid Services (CMS), please include the zip code for the point of pick up. You can report the physical pick up and drop off addresses in field 32.

Field 24: NDC - When submitting an NDC the NDC should be submitted in the shaded area and should be preceded with the qualifier N4, followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML number. The total dosage administered in mgs or mls can be reported in box 24 (the shaded section) and should not be reported in the Units field. The Units field on the CMS-Form 1500 (02-12) box 24G represents the number of units based on the NDC number. (milliliter).

Field 24A: Date(s) of Service Field
Field 24B: Place of Service
Field 24D: Procedures, Services or Supplies – Enter the appropriate CPT, HCPCS code/nomenclature; include a narrative description for Non Specific (NOC) codes. Do not use NOC codes when a specific CPT code is available. Please indicate appropriate modifier when applicable.

Field 24E: Diagnosis Pointer – refer to field 21 - Be sure to enter the diagnosis code reference (pointer) from Field 21 to relate the date of service and the procedures performed to the primary diagnosis. When multiple services are performed, the primary reference number for each service should be listed first, other applicable services should follow. The references were changed from numeric to alpha characters on the updated 02/12 form version. Be sure to use alpha characters (A-L) and not numerics in this field.

Field 24F: $ Charges – line item charge.
Field 24G: Days or Units - When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units.

Field 24J: Lower: National Provider Identification number (NPI)

Field 25: Federal Tax ID Number (9-digit)

Field 28: Total Charge – total of line item charges.

Field 31: Full name and title of Physician or Supplier – actual signature or typed/printed designation is acceptable.

Field 32: Service Facility Location Information – Address where services were rendered

Field 32a: Providers National Provider Identification number (NPI) – Service location NPI

Field 33: Billing Provider Information and Phone # - Complete name, address, city, state and zip code

Field 33a: Physician’s National Provider Identification number (NPI) – Billing Provider NPI

Note: To help improve payment accuracy and timeliness, please remember that when filing claims, the Tax Identification Number (TIN) and National Provider Identifier (NPI) numbers are required. Additionally, bill your claims using the taxonomy codes as applicable.

Include the following information on electronic claim submissions:
- Billing provider NPI
- Rendering provider NPI, if different from the billing provider NPI
- Pay to address name, Loop 2010AB NM1 segment
- Pay to address, Loop 2010AB N3 segment
- Pay to address city, state and zip code, Loop 2010AB N4 segment

Providers with 1 tax ID, 1 NPI and MULTIPLE Specialties should include the Taxonomy code that applies to the services performed and reported on the claim submission to help ensure the claim is processed with the correct provider specialty.
- Taxonomy code should be populated in Loops 2000A and 2310B PRV segment:
  - Billing Provider Specialty – Loop 2000A PRV03
  - Rendering Provider Specialty – Loop 2310B PRV03

Additional taxonomy codes and information can be found on the Washington Publishing Company Web site [www.wpc-edi.com/taxonomy](http://www.wpc-edi.com/taxonomy)
<table>
<thead>
<tr>
<th>Column 1</th>
<th>Column 2</th>
<th>Column 3</th>
<th>Column 4</th>
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<tr>
<td>Column 5</td>
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**HEALTH INSURANCE CLAIM FORM**

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 2012

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**Ohio Provider Manual © Community Insurance Company**

41
Recommended Fields for UB-04 (CMS-1450)

If these fields are not completed, your claim may be delayed or returned to your for additional information.

For Inpatient UB-04 Claim Forms - these fields must be completed:

Field 1:  Provider name and complete address
Field 2:  Provider’s designated billing name and remittance address
Field 4:  Type of Bill
Field 5:  Federal Tax Identification Number
Field 6:  Statement Covers Period (From-Through)
Field 8:  Patient Name
Field 9:  Patient Address
Field 10: Birth Date (format mmddccyy)
Field 11: Sex
Field 12: Admission Date
Field 13: Admission Hour
Field 14: Admission Type – Priority (Type) of Admission or Visit
Field 15: Admission SRC – Point of Origin for Admission or Visit
Field 16: Discharge Hour
Field 17: Patient Discharge Status
Fields 31 - 34: Occurrence Codes and Dates
Fields 39-41: Value Code(s) and Amounts

- If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of A1, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.

- If there is a Value Code present and not equal to 02 there must be a Value Code amount.

The Value Codes to be submitted when billing Private Room Revenue codes according to the UB-04 Data Specifications Manual 2014 and CMS Manual Transmittal 1104 are:

- “01” (semi-private room facility) must be accompanied by the semi-private room rate when the facility offers semi-private rooms and the patient’s stay is in a private room
- “02” indicating “private room only” facility with $0.00 when the facility is private room only

The following is a quick overview of the most common errors we are seeing on fields 39, 40 and 41, when Medicare is primary and Anthem is secondary:

- Value codes are missing. Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.
- The member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits). If there is a deductible amount indicated on the primary payer’s remittance advice, the UB04 must include the member deductible (A1, B1 or C1 value code) and amount.
- The coinsurance amount is missing. If there is coinsurance on the primary payer’s remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- The copay amount is missing. If there is copayment on the primary payer’s remittance advice, the UB04 must include
• Blood deductible is not noted. If there is blood deductible on the payer’s remittance advice, the value code 06 must be on the claim, along with the amount.

• There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a beforepopulating 39b, 40b, or 41b.

• The value code and remittance advice amounts are different. In all cases, the value code and remittance advice amounts must match.

Field 42: Revenue Code(s) - When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted.

Field 43: Description – NDC - When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11-digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML (milliliter). The total dosage administered in mgs or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number. (milliliter).

Field 44: HCPCS/Accommodation Rates/HIPPS Rate Codes

Field 45:

Service Date
Field 46: Service Units Field 47: Total Charges
Field 56: Providers National Provider Identification number (NPI)

Field 58: Insured’s Name
Field 59: Patient’s Relationship
Field 60: Insured Unique ID – from Covered Individual ID card, including any prefix/suffix
Field 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision for dates of service prior to 10/01/2015 or 0 - Tenth Revision for dates of service 10/01/2015 and later.

Field 67: Principal Diagnosis Code and Present on Admission (POA) Indicator
Fields 67A - Q: Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)
Field 74:

Principal Procedure Code and Date
For Outpatient UB-04 (CMS-1450) Claim Forms - these fields must be completed: Field 1:

Provider name and complete address
Field 2: Provider’s designated billing name and remittance address
Field 4: Type of Bill
Field 5: Federal Tax Identification Number
Field 6: Statement Covers Period (From-Through)
Field 8:

Patient Name
Field 9: Patient Address
Field 10: Birth Date (format mmdccyy)

Field 11: Sex

Field 12: Admission Field 13: Admission Hour

Fields 31 - 34: Occurrence Codes and Dates

Fields 39-41: Value Code(s) and Amounts

Field 42: Revenue Code(s)

Field 43: Description – NDC - When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriateQualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML (milliliter). The total dosage administered in mgs or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number. (milliliter).

Field 44: HCPCS/Accommodation Rates/HIPPS Rate Codes

Field 45: Service Date Field 46: Service Units

Field 47: Total Charges

Field 56: Providers National Provider Identification number (NPI)

Field 57: Insured’s Name

Field 59: Patient’s Relationship

Field 60: Insured’s Unique ID – from Covered Individual ID card, including any alpha prefix

Field 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator) - The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 - Ninth Revision for dates of service prior to 10/01/2015 or 0 - Tenth Revision for dates of service 10/01/2015 and later.

Field 67: Principal Diagnosis Code and Present on Admission (POA) Indicator

Fields 67A - Q: Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)

Field 74: Principal Procedure Code
<table>
<thead>
<tr>
<th>Column</th>
<th>Description</th>
<th>Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Claim Type</td>
<td>04</td>
</tr>
<tr>
<td>2</td>
<td>Claim ID</td>
<td>0000000000</td>
</tr>
<tr>
<td>3</td>
<td>Insurance Company</td>
<td>Community Insurance Company</td>
</tr>
<tr>
<td>4</td>
<td>Provider Name</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Provider NPI</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Provider EIN</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Date of Service</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Diagnosis Code</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Diagnosis Description</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Procedure Code</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Procedure Description</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Amount Charged</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Amount Allowed</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Amount Paid</td>
<td></td>
</tr>
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</table>

**PAGE** __ of __ **CREATION DATE**

**TOTALS**

<table>
<thead>
<tr>
<th>Column</th>
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<tbody>
<tr>
<td>50</td>
<td>Payer Name</td>
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</tr>
<tr>
<td>51</td>
<td>Payer ID</td>
<td></td>
</tr>
<tr>
<td>52</td>
<td>Payer ID</td>
<td></td>
</tr>
<tr>
<td>53</td>
<td>Patient Name</td>
<td></td>
</tr>
<tr>
<td>54</td>
<td>Patient ID</td>
<td></td>
</tr>
<tr>
<td>55</td>
<td>Facility Name</td>
<td></td>
</tr>
<tr>
<td>56</td>
<td>Facility ID</td>
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<td>58</td>
<td>Provider Name</td>
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<td>Provider ID</td>
<td></td>
</tr>
<tr>
<td>60</td>
<td>Provider ID</td>
<td></td>
</tr>
</tbody>
</table>

**RECEIVED** __ of __ **RECEIVED DATE**

**ATTACHMENTS**

**CERTIFIED**

The certifications on the reverse apply to this bill and are made a part hereof.
Provider Claim Correspondence Filing Tips:

If you believe a claim was not processed correctly according to the terms of your contract, for example, you believe the allowable is not correct. You can submit a Provider Adjustment Request Form or send a secure message through Availity no later than two (2) years from the date the claim was paid. The Provider Adjustment Request Form can be found on our public provider website under Answers@Anthem, Provider Forms. Please follow the instructions for completion and mailing.

Here are some additional tips that will help to ensure appropriate routing of your request.

- Submit one Provider Adjustment Request Form for each claim. Do not submit lists of multiple claims on one Provider Adjustment Request Form. Requests with multiple claims attached will be returned.

- Always include a valid and complete member identification number including the three digit alpha prefix or R+8 digits for Federal Employee Program® (FEP®) members on the first page.

- Clearly identify the date of service in question on the first page.

- Insure that all information is legible whether it is printed or hand-written.

- When submitting a correction to a previously submitted claim, submit the entire claim as a replacement claim if you have omitted charges or changed claim information (i.e., diagnosis codes, procedure codes, dates of service, etc.) including all previous information and any corrected or additional information. To correct a claim that was billed to Anthem in error, submit the entire claim as a void/cancel of prior claim. Please see guidance below:

<table>
<thead>
<tr>
<th>Type</th>
<th>Professional Claim</th>
<th>Institutional Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td>EDI</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To indicate the claim is a replacement claim:</td>
<td>To indicate the claim is a replacement claim:</td>
</tr>
<tr>
<td></td>
<td>- In element CLM05-3 “Claim Frequency Type Code”</td>
<td>- In element CLM05-3 “Claim Frequency Type Code”</td>
</tr>
<tr>
<td></td>
<td>- Use Claim Frequency Type 7</td>
<td>- Use Claim Frequency Type 7</td>
</tr>
<tr>
<td></td>
<td>To confirm the claim which is being replaced:</td>
<td>To confirm the claim which is being replaced:</td>
</tr>
<tr>
<td></td>
<td>- In Segment “REF – Payer Claim Control Number”</td>
<td>- In Segment “REF – Payer Claim Control Number”</td>
</tr>
<tr>
<td></td>
<td>- Use F8 in REF) and list the original payer claim number is REF02</td>
<td>- Use F8 in REF) and list the original payer claim number is REF02</td>
</tr>
<tr>
<td></td>
<td>To indicate the claim was billed in error (Void/Cancel)</td>
<td>To indicate the claim was billed in error (Void/Cancel)</td>
</tr>
<tr>
<td></td>
<td>- In element CLM05-3 “Claim Frequency Type Code”</td>
<td>- In element CLM05-3 “Claim Frequency Type Code”</td>
</tr>
<tr>
<td></td>
<td>- Use Claim Frequency Type 8</td>
<td>- Use Claim Frequency Type 8</td>
</tr>
<tr>
<td></td>
<td>To confirm the claim which is being void/cancelled:</td>
<td>To confirm the claim which is being void/cancelled:</td>
</tr>
<tr>
<td></td>
<td>- In Segment “REF – Payer Claim Control Number”</td>
<td>- In Segment “REF – Payer Claim Control Number”</td>
</tr>
<tr>
<td></td>
<td>- Use F8 in REF) and list the original payer claim number is REF02</td>
<td>- Use F8 in REF) and list the original payer claim number is REF02</td>
</tr>
<tr>
<td>Paper</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>To indicate the claim is a replacement claim:</td>
<td>To indicate the claim is a replacement claim:</td>
</tr>
<tr>
<td></td>
<td>- In Item Number 22: “Resubmission and/or Original Reference Number”</td>
<td>- In Form Locator 04: “Type of Bill”</td>
</tr>
<tr>
<td></td>
<td>- Use Claim Frequency Type 7 under “Resubmission Code”</td>
<td>- Use Claim Frequency Type 7</td>
</tr>
<tr>
<td></td>
<td>To confirm the claim which is being replaced:</td>
<td>To confirm the claim which is being replaced:</td>
</tr>
</tbody>
</table>
To confirm the claim which is being replaced:

- In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer claim number for the resubmitted claim.

To indicate the claim is a void/cancel of a prior claim:

- In Item Number 22: "Resubmission and/or Original Reference Number"
- Use Claim Frequency Type 8 under "Resubmission Code"

To confirm the claim which is being void/cancelled:

- In the right-hand side of Item Number 22 under "Original Ref. No." list the original payer claim number for the void/cancelled claim.

- In Form Locator 64: "Document Control Number (DCN)" list the original payer claim number for the resubmitted claim.

To indicate the claim is a void/cancel of a prior claim:

- In Form Locator 04: "Type of Bill"
- Use Claim Frequency Type 8

To confirm the claim which is being void/cancelled:

- In Form Locator 64: "Document Control Number (DCN)" list the original payer claim number for the void/cancelled claim.

- If you are submitting medical records requested by Anthem, be sure to attach a copy of our request letter to the top of the records.

- If you are submitting medical records on compact disk (CDs), do not password protect the CDs. Remember to include a valid and complete member identification number on page one of the material sent with these records.

- If you are submitting X-Rays, pictures or dental molds, remember to include a valid and complete member identification number on page one of the material sent with these items.

- If you are not including any attachments with your request, you may receive a faster response by sending a Secure Message via the Availity Web Portal.

- Contact Utilization Management for information on precertification or predetermination requests. If you disagree with a clinical decision, please follow the directions detailed on our letter. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.

For additional information on provider complaints and appeals, please see the Guide to Provider Complaints and Appeals on our public provider website under Answers@Anthem.

**Electronic Data Interchange ("EDI") Overview**

Anthem recommends using the EDI system for Claims submission. Electronic Claims submissions can help reduce administrative and operating costs, expedite the Claim process, and reduce errors. Providers and Facilities who use EDI can electronically submit Claims and receive acknowledgements 24 hours a day, 7 days a week.

Electronic Funds Transfer Election - Should Provider or Facility elect to receive payments via Electronic Fund Transfer, such election may be deemed effective by Anthem for any Claim your Agreement with Anthem pertains to. Anthem may share information about Providers or Facilities, including banking information, with third parties to facilitate the transfer of funds to Provider or Facility accounts.

There are several methods of transacting Anthem Claims through the Electronic Data Interchange process. You can use electronic Claims processing software to submit Claims directly, or you can use an EDI vendor that may also offer additional services, including the hardware and software needed to automate other tasks in your office. No matter what method you choose, Anthem does not charge a fee to submit electronically.
Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

**Additional Information**

For additional information concerning electronic claims submission and other electronic transactions, you can click the Electronic Data Interchange (EDI) link below or on the Provider Home page at Anthem.com.

**Access Electronic Data Interchange (EDI) Services**

**Overpayments**

Anthem’s *Cost Containment Overpayment Avoidance* Division reviews Claims for accuracy and requests refunds if Claims are overpaid or paid in error. Some common reasons for overpayment are:

- Paid wrong provider / Covered Individual
- Allowance overpayments
- Billed in error
- Non-covered services
- Terminated Covered Individuals
- Paid wrong Covered Individual / provider number
- Coordination of Benefits
- Late credits
- Duplicate
- Claims editing
- Total charge overpaid

**Anthem Identified Overpayments (aka “Solicited”)**

When refunding Anthem on a Claim overpayment that Anthem has requested, please use the payment coupon included on the request letter and the following information with your check:

**The payment coupon**

- Covered Individual ID number
- Covered Individual’s name
- Claim number
- Date of service
- Reason for the refund as indicated in our refund request letter

As indicated in the Anthem refund request letter and in accordance with provider contractual language, provider overpayment refunds not received and applied within the timeframe indicated will result in Claim recoupment.

Providers and Facilities may direct disputes of amounts indicated on an Anthem refund request letter to the address indicated on the letter.

**Provider and Facility Identified Overpayments (aka “voluntary” or “unsolicited”)**

If Anthem is due a refund as a result of an overpayment discovered by a Provider or Facility, refunds can be made in one of the following ways:

- Submit a refund check with supporting documentation outlined below, or
- Submit the [Provider Adjustment Request Form] with supporting documentation to have claim adjustment/recoupment done off a future remittance advice

When voluntarily refunding Anthem on a Claim overpayment, please include the following information:

- Provider Adjustment Request form
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate. 
- Covered Individual ID number
- Covered Individual’s name
- Claim number
- Date of service
- Reason for the refund as indicated in the above list overpayment reasons.

Please be sure the copy of the provider remittance advice is legible and the Covered Individual information that relates to the refund is circled. By providing this critical information, Anthem will be able to expedite the process, resulting in improved service and timeliness to Providers and Facilities.

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**Important Note:** If a Provider or Facility is refunding Anthem due to coordination of benefits and the Provider or Facility believes Anthem is the secondary payer, please refund the full amount paid. Upon receipt and insurance primacy verification, the Claim will be reprocessed and paid appropriately.

**How to access the Provider Adjustment Request form online:**

To download the “Provider Adjustment Form” directly from anthem.com, select Menu and then under the Support heading select the “Providers” link. Choose the applicable state from the drop down box and press enter. On the provider home page, select Answers@Anthem on the menu bar. On the Answers@Anthem page, select “Provider Forms” and “Provider Adjustment Request Form”. Providers can also reference the Links section of the manual for the direct link information.

**Please utilize the proper address noted in the grid below to return payment:**

<table>
<thead>
<tr>
<th>State</th>
<th>Line of Business (Blue Branded)</th>
<th>Type of Refund</th>
<th>Make Check Payable To:</th>
<th>Regular Mailing Address:</th>
<th>Overnight Delivery Address:</th>
</tr>
</thead>
<tbody>
<tr>
<td>IN, KY, OH, MO, WI, CT, ME, NH, VA</td>
<td>All</td>
<td>Voluntary</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>Central Region-CCOA Lockbox PO Box 73651 Cleveland, OH 44193-1177</td>
<td>Anthem Central Lockbox 73651 4100 West 150th Street Cleveland, Ohio 44135</td>
</tr>
<tr>
<td>IN, KY, OH, MO, WI, CT, ME, NH, VA</td>
<td>All</td>
<td>Solicited Refund with Coupon Letter</td>
<td>Anthem Blue Cross and Blue Shield</td>
<td>Anthem Blue Cross and Blue Shield PO Box 5281 Carol Stream, IL 60197</td>
<td></td>
</tr>
</tbody>
</table>

**Medicare Crossover**

**Duplicate Claims Handling for Medicare Crossover**

Since January 1, 2006, all Blue Plans have been required to process Medicare crossover Claims for services covered under Medigap and Medicare Supplemental products through Centers for Medicare & Medicaid Services (CMS). This has resulted in automatic submission of Medicare Claims to the Blue secondary payer to eliminate the need for Provider or Facilities or his/her/its billing service to submit an additional Claim to the secondary carrier. Additionally, this has also allowed Medicare crossover Claims to be processed in the same manner nationwide.

Effective October 13, 2013 when a Medicare Claim has crossed over, Providers and Facilities are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Covered Individual's Blue Plan.

To avoid the submissions of duplicate Claims, use the 276/277 Health care Claims status inquiries to verify Claim and adjudication status prior to re-submission of electronic Claims.

If Provider or Facility provides Covered Individuals’ Blue Plan ID numbers (including alpha prefix) when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider or Facility receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for Provider or Facility to receive payment or instructions from the Blue Plan.

Providers and Facilities should continue to submit services that are covered by Medicare directly to Medicare. Even if Medicare may exhaust or has exhausted, continue to submit Claims to Medicare to allow for the crossover process to occur and for the Covered Individual’s benefit policy to be applied.

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Medicare primary Claims, including those with Medicare exhaust services, that have crossed over and are received within 30 calendar days of the Medicare remittance date or with no Medicare remittance date, will be rejected by the local Plan.

Effective October 13, 2013, we will reject Medicare primary provider submitted Claims with the following conditions:

- Medicare remittance advice remark codes MA18 or N89 that Medicare crossover has occurred
  - MA18 Alert: The Claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.
  - N89 Alert: Payment information for this Claim has been forwarded to more than one other payer, but format limitations permit only one of the secondary payers to be identified in this remittance advice.
- Received by Provider or Facility's local Plan within 30 calendar days of Medicare remittance date
- Received by Provider or Facility's local Plan with no Medicare remittance date
- Received with GY modifier on some lines but not all
  - A GY modifier is used by Providers and outpatient Facilities when billing to indicate that an item or service is statutorily excluded and is not covered by Medicare. Examples of statutorily excluded services include hearing aids and home infusion therapy.

When these types of Claims are rejected, Anthem will also remind the Provider or Facility to allow 30 days for the crossover process to occur or instruct the Provider or Facility to submit the Claim with only GY modifier service lines indicating the Claim only contains statutorily excluded services.

Medicare statutorily excluded services – just file once to your local Plan

There are certain types of services that Medicare never or seldom covers, but a secondary payer such as Anthem may cover all or a portion of those services. These are statutorily excluded services. For services that Medicare does not allow, such as home infusion, Providers and outpatient Facilities need only file statutorily excluded services directly to their local Plan using the GY modifier and will no longer have to submit to Medicare for consideration. These services must be billed with only statutorily excluded services on the Claim and will not be accepted with some lines containing the GY modifier and some lines without.

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers and Facilities can expect the Covered Individual’s benefit plan to reject the Claim advising the Provider or Facility to submit to their local Plan when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility's local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider or Facility contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider’s or Facility’s contractual agreement.

Effective October 13, 2013:

- Providers or outpatient Facilities who render statutorily excluded services should indicate these services by using GY modifier at the service line level of the Claim.
- Providers or Facilities will be required to submit only statutorily excluded service lines on a Claim (cannot combine with other services like Medicare exhaust services or other Medicare covered services)
- The Provider or outpatient Facility’s local Plan will not require Medicare EOMB for statutorily excluded services submitted with a GY Modifier.

If Providers or outpatient Facilities submit combined line Claims (some lines with GY, some without) to their local Plan, the Provider or outpatient Facility’s local Plan will deny the Claims, instructing the Provider or outpatient Facility to split the Claim and resubmit.
Original Medicare – The GY modifier should be used when service is being rendered to a Medicare primary Covered Individual for statutorily excluded service and the Covered Individual has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be “P” to denote primary.

Medicare Advantage – Please ensure SBR01 denotes “P” for primary payer within the 837 electronic Claim file. This helps ensure accurate processing on Claims submitted with a GY modifier.

The GY modifier should not be used when submitting:

- Federal Employee Program Claims
- Inpatient institutional Claims. Please use the appropriate condition code to denote statutorily excluded services.

These processes align Blue Cross and/or Blue Shield plans with industry standards and will result in less administrative work, accurate payments and fewer rejected Claims. Because the Claim will process with a consistent application of pricing, our Covered Individuals will also see a decrease in health care costs as the new crossover process eliminates or reduces balance billing to the Covered Individual.

Medicare Crossover Claims FAQs

1. How do I handle traditional Medicare-related claims?
   - When Medicare is primary payer, submit claims to your local Medicare intermediary.
   - All Blue claims are set up to automatically cross over (or forward) to the Covered Individual’s Blue Plan after being adjudicated by the Medicare intermediary.

2. How do I submit Medicare primary / Blue Plan secondary claims?
   - For Covered Individuals with Medicare primary coverage and Blue Plan secondary coverage, submit claims to your Medicare intermediary and/or Medicare carrier.
   - When submitting the claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Covered Individual’s ID card for additional verification.
   - Be certain to include the alpha prefix as part of the Covered Individual identification number. The Covered Individual’s ID will include the alpha prefix in the first three positions. The alpha prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

   When you receive the remittance advice from the Medicare intermediary, look to see if the claim has been automatically forwarded (crossed over) to the Blue Plan:

   - If the remittance advice indicates that the claim was crossed over, Medicare has forwarded the claim on your behalf to the appropriate Blue Plan and the claim is in process. **DO NOT** resubmit that claim to Anthem; duplicate claims will result in processing and payment delays.
   - If the remittance advice indicates that the claim was not crossed over, submit the claim to your local Anthem Plan with the Medicare remittance advice.
   - In some cases, the Covered Individual identification card may contain a COBA ID number. If so, be certain to include that number on your claim.
   - For claim status inquiries, please contact your local Anthem Plan.

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3. Who do I contact with claims questions?
   - Your local Anthem Plan.

4. How do I handle calls from Covered Individuals and others with claims questions?
   - If Covered Individuals contact you, tell them to contact their Blue Plan. Refer them to the front
     or back of their ID card for a customer service number.
   - A Covered Individual’s Blue Plan should not contact you directly, unless you filed a paper
     claim directly with that Blue Plan. If the Covered Individual’s Blue Plan contacts you to send
     another copy of the Covered Individual’s claim, refer the Blue Plan to your local Anthem Plan.

5. Where can I find more information?
   For more information:
   - Please contact your local Anthem Plan.

Reimbursement Policies and Procedures

Blood, Blood Products, Processing, Storage and Administration

Blood and blood products such as platelets or plasma are reimbursable. Blood product processing fees
(typing, serology and cross-matching and blood storage) are also reimbursable. However, transportation
charges are included in the reimbursement for the product itself and are not separately reimbursable. Blood
and blood product administration services are reimbursable only on an outpatient basis when billed hourly or
as a flat rate with total eligible Charges capped at the average approved semi-private room rate less
discount. Blood and blood product administration services are not reimbursable on inpatient claims.

Changes During Admission

There are 5 elements that could change during an admission. The following table shows the scenarios and
the date to be used:

<table>
<thead>
<tr>
<th>CHANGE</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Insurance Coverage</td>
<td>Admission</td>
</tr>
<tr>
<td>Facility’s Payment Methodology</td>
<td>Admission</td>
</tr>
<tr>
<td>Facility’s Payment Rate</td>
<td>Admission</td>
</tr>
<tr>
<td>DRG Grouper Version</td>
<td>Discharge</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>Discharge</td>
</tr>
</tbody>
</table>

The member’s deductible, coinsurance, copay and benefits in effect upon admission are in effect for the
entire claim.

The payment methodology and rate used are those in effect on admission (i.e., if the hospital's payment
methodology changed during an admission from Per Diem to DRG, the entire admission is paid Per Diem; if
the DRG Rate increased from $4,500 to $4,750, the claim is paid using the $4,500 DRG Rate).

The DRG Grouper Version, as well as the DRG Relative Weight used are the ones in effect upon discharge.
These changes can only occur with admissions that span 10/1, concurrent with CMS updates. The other
changes could occur anytime, including admissions that span 10/1, concurrent with CMS updates.
Coding Requirements

Providers and Facilities will submit Claims in a format consistent with industry standards and acceptable to Anthem.

Comprehensive Health Planning

Facility shall not bill Plan or a Covered Individual for Health Services, expanded facilities, capital operating costs or any other matter of service requiring a certificate of need approval or exemption under existing law, or similar or successor laws that may be adopted from time to time, unless said approval or exemption has been granted in writing.

Coordination of Benefits/Subrogation

When payment for Covered Services is subject to either coordination of benefits or subrogation between two (2) or more sources of payment and Anthem is not the primary source, payment shall be based upon the Anthem Rate for the applicable network/program in which the Covered Individual participates, reduced by the amount paid for the Covered Services by other source(s). Providers and Facilities agree to accept such amount as payment in full for the Covered Services and shall not balance bill the Covered Individual. Notwithstanding the foregoing, this provision shall not be construed to require Provider or Facility to waive Cost Shares in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation.

To the extent permitted by law, Plan may, under third party liability, third party recovery, or similar provisions of Health Benefit Plans, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Plan. However, the right of Plan to such a refund will not, in any case, affect or increase the maximum compensation to which Provider or Facility is entitled under the Agreement for any services that are, or in the absence of Plan's right to such refund would be, Covered Services.

Courtesy Room

Facility shall not bill Anthem, Plan, and/or Covered Individuals for any charges related to use of a Courtesy Room in the provision of Health Services to a Covered Individual. "Courtesy Room" means an area in the Facility where a professional provider is permitted by Facility to provide Health Services to Covered Individuals, which could otherwise be provided in an office setting.

Daily Supply or One Time Charge Fees/Items

Supply fees billed daily or one time, which are unidentified and unsupported by medical records or documentation are not reimbursable. Examples of daily supplies include those commonly used services and supplies provided in relatively equal quantities to all patients in similar circumstances. It also includes those inexpensive supplies and medications for which it is uneconomical to account separately.

Different Settings Charges

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

Eligibility and Payment

A guarantee of eligibility is not a guarantee of payment.

Emergency Room Supply and Service Charges

The Emergency Room level reimbursement includes all monitoring, equipment, supply, time and staff charges. Reimbursement for the use of the Emergency Room includes the use of the room and personnel employed for the examination and treatment of patients. This reimbursement does not typically include the cost of physician services.
Facility Personnel Charges

Charges for Inpatient Services for Facility personnel are not separately reimbursable and the reimbursement for such is included in the room and board rate. Examples include, but are not limited to, lactation consultants, dietary consultants, overtime charges, transport fees, nursing functions, call back charges, nursing increments and respiratory services. Outpatient Services for Facility personnel are also not separately reimbursable. Reimbursement is included in the reimbursement for the procedure or observation charge.

Implants

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

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

Instrument Trays

Charges for instrument trays for any procedure are included in the cost of the procedure and are not separately reimbursable. See Operating Room Time and Procedure Charges for additional information.

Interim Bill Claims

Anthem shall not adjudicate Claims submitted as interim bills for services reimbursed under DRG methodology.

IV Sedation - IV sedation and local anesthesia

Administered by the provider performing the procedure, and/or nursing personnel, is not separately reimbursable and is included as part of the OR time/procedure reimbursement.

Labor Care Charges

Plan will reimburse appropriately billed room and board or labor charges. Payment will not be made on both charges billed concurrently. Facilities reimbursed under DRG may not bill for Outpatient Services rendered prior to the admission.

Medical Care Provided to or by Family Members

Services for any type of medical care rendered by a Provider to him/herself or to an immediate family member (as defined below), who is a Covered Individual, are not eligible for coverage and should not be billed to Anthem. In addition, a Provider may not be selected as a Primary Care Physician (PCP) by his/her immediate family member.


Non-Participating Provider Claims Payment Policy

Anthem has established Maximum Allowed Amounts for services rendered by non-participating providers. Once Anthem determines the appropriate Maximum Allowed Amount for services provided by a non-participating provider, the payment will be remitted to the Covered Individual in most situations and not the
non-participating provider.

Nursing Procedures

Plan will not separately reimburse fees associated with nursing procedures or services provided by Facility nursing staff or unlicensed facility personnel (technicians) performed during an inpatient ("IP") admission or outpatient ("OP") visit. Examples include, but are not limited, to intravenous ("IV") injections or IV fluid administration/monitoring, intramuscular ("IM") injections, subcutaneous ("SQ") injections, nasogastric tube ("NGT") insertion, urinary catheter insertion, point of care/bedside testing (such as glucose, blood count, arterial blood gas, clotting time, etc.) and inpatient blood transfusion administration/monitoring (with the exception of OP blood administration or OP chemotherapy administration which are submitted without observation/treatment room charges.)

Observation Services Policy

Description

Anthem considers outpatient observation services to mean active, short-term medical and/or nursing services performed by an acute facility on that facility’s premises that includes the use of a bed and monitoring by that acute facility’s nursing or other staff and are required to observe a patient’s condition to determine if the patient requires an inpatient admission to the facility. Observation services include services provided to a patient designated as “observation status”, and in general, shall not exceed 24 hours. Observation services may be considered eligible for reimbursement when rendered to patients who meet one or more of the following criteria:

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

Policy

The payment, if any, for observation services is specified in the Plan Compensation Schedule or Contract with the applicable Facility. Nothing in this Policy is intended to modify the terms and conditions of the Facility’s agreement with Anthem. If the Facility’s agreement with Anthem does not provide for separate reimbursement for observation services, then this Policy is not intended to and shall not be construed to allow the Facility to separately bill for and seek reimbursement for observation services.

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

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

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

Operating Room Time and Procedure Charges

The operating room ("O.R.") charge will be based on a time or procedural basis. When time is the basis for the charge, it should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse’s notes. The operating room charge will reflect the cost of:

• The use of the operating room
• The services of qualified professional and technical personnel
• Linen packs, basic instrument packs, basic packs, basic post-op dressing, equipment and routine supplies such as sutures, gloves, dressings, sponges, prep kits, drapes, and surgical attire.

Separate charges are allowed for specialized packs such as those used for open heart, eye and scope surgeries, packs for extensive plastic repair and complex post-op dressing or specialized equipment such as hip pins, bone nails, bone plates, and tantalum mesh. This includes the cost of preparing, storing and handling such supplies.

The operating room charge will not reflect the cost of robotic technology and is not eligible for separate reimbursement. Examples of charges that are not eligible for separate or additional reimbursement are listed below.

Increased operating room unit cost charges for the use of the robotic technology
Charges billed under CPT or HCPCS codes that are specific to robotic assisted surgery, including, but not limited to, S2900.

Other Agreements Excepted

If Facility currently maintains a separate agreement(s) with Anthem solely for the provision and payment of home health care services, skilled nursing facility services, ambulatory surgical facility services, or other agreements that Anthem designates (hereinafter collectively "Other Agreement(s)"), said Other Agreement(s) will remain in effect and control the provision and payment of Covered Services rendered there under.

Personal Care Items

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

Pharmacy Charges

Pharmacy charges will include the cost of the drugs prescribed by the attending physician. Medications furnished to patients shall not include an additional separate charge for administration of drugs, the cost of materials necessary for the preparation and administration of drugs, and the services rendered by registered pharmacists and other pharmacy personnel. Anthem will reimburse at the Anthem Rate for the drug. All other services are included in the Anthem Rate. Example of pharmacy charges which are not separately reimbursable include, but are not limited to: IV mixture fees and Facility staff checking the pharmacy ("RX") cart.
Place of Service and Evaluation & Management Facility Reimbursement Policy

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

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

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

Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider, must be billed on a CMS-1500 claim form and are not reimbursable if they are billed on a UB-04 claim form.

- Anthem shall not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 claim form.

- Anthem does not reimburse for professional E&M charges billed on a UB-04 claim form regardless of where services are rendered; reimbursement for these charges are included in the professional fee allowance.

- All professional services including, but not limited to, those rendered by hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, physical therapists, occupational therapists, speech therapists, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a CMS-1500 claim form using the appropriate CPT®/HCPCS codes.

- Services rendered outside of the primary structure on the campus of a hospital or an institutional provider shall not be billed or reimbursed on a UB-04 claim form. The Covered Individual is not responsible for these charges. Examples of Revenue Codes under which such services shall not be billed or reimbursed include, but are not limited to, the following groupings:

  0280 – 0289 Oncology Clinic
  0300 – 0309 Laboratory
  0300 – 0319 Laboratory Pathological
  0320 – 0329 Radiology Diagnostic
  0330 – 0339 Radiology – Therapeutic and/or Chemotherapy Administration
  0340 – 0349 Nuclear Medicine
  0350 – 0359 CT Scan
  0420 – 0429 Physical Therapy
  0430 – 0439 Occupational Therapy
  0440 – 0449 Speech Therapy
  0481 – 0489 Cardiology Clinic
  0510 – 0519 Clinic
Professional E&M services shall not be billed or reimbursed on a UB-04 Claim form. The Covered Individual is not responsible for these charges.

**Portable Charges**

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

**Pre-Operative Care or Holding Room Charges**

Charges for a pre-operative care or a holding room used prior to a procedure are included in the reimbursement for the procedure, and are not separately reimbursed. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Reimbursement for the procedure includes all nursing care provided.

**Preparation (Set-Up) Charges**

Charges for set-up, equipment or materials in preparation for procedures or tests are included in the reimbursement for that particular procedure or test.

**Preventable Adverse Events ("PAE") Policy**

**Acute Care General Hospitals (Inpatient)**

**Three (3) Major Surgical Never Events**

When any of the Preventable Adverse Events ("PAEs") set forth in the grid below occur with respect to a Covered Individual, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Plan or the Covered Individual for such events. If acute care general hospital receives any payment from the Plan or the Covered Individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with Anthem in any Anthem initiative designed to help analyze or reduce such PAEs. Whenever any of the events described in the grid below occur with respect to a Covered Individual, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission ("TJC"), or a patient safety organization ("PSO") certified and listed by the Agency for Healthcare Research and Quality.

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

Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.

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**CMS Hospital Acquired Conditions (“HAC”)**

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

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

**Providers and Facilities (excluding Inpatient Acute Care General Hospitals)**

**Four (4) Major Surgical Never Events**

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

Whenever any of the events described in the grid below occur with respect to a Covered Individual, Providers and Facilities are encouraged to report the PAE to the appropriate state agency, The Joint Commission (“TJC”), or a patient safety organization (“PSO”) certified and listed by the Agency for Healthcare Research and Quality.

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</tr>
<tr>
<td>4. Retention of a foreign object in a patient after surgery or other procedure</td>
<td>Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.</td>
</tr>
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</table>
Provider and Facility Records

Provider and Facility shall prepare and maintain all appropriate medical, financial, administrative and other records as may be needed for Covered Individuals receiving Health Services. All of Provider’s and Facility’s records on Covered Individuals shall be maintained in accordance with prudent record keeping procedures and as required by any applicable federal, state or local laws, rules or regulations.

Psychiatric Outpatient/Residential Services

The billing requirements for psychiatric outpatient/residential services apply to each approved and medically necessary service date in a licensed psychiatric outpatient/residential program, and include payment for all services rendered during a psychiatric outpatient/residential visit including, but not limited to, facility use (that includes all nursing care), laboratory, radiology, supplies, equipment, pharmaceuticals, and all other services incidental to the outpatient/residential visit. A psychiatric outpatient/residential visit means a single service date.

Anthem recognizes the below Levels of Care. These levels differ in terms of the degree of services required, as defined by the combination of ICD-9 or successor diagnosis codes and revenue codes.

Level 1
Intensive outpatient structured program (e.g., evening care) and partial hospitalization (three to five (3 to 5) hours per day); Level 1 is the default, unless Level 2 is approved by utilization management.

Level 2
This includes partial hospitalization (six to eight (6 to 8) hours per day), residential care and outpatient electroconvulsive therapy. All Level 2 care requires utilization review approval/certification.

Special billing instructions and requirements:
1. ICD-9 or successor diagnosis codes must be included for each care level. The appropriate ICD-9 or successor codes are 290.0 to 319.
2. Appropriate revenue codes must be included for each care level.
3. Utilization management must approve the level of care for all services.
4. Each service date must be billed as a separate line item.
5. Whole hours must be used to indicate hours of care in the “Service Units” field. Show whole hours in form locator 46.

Recovery Room Charges

Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient’s welfare and safety during his/her confinement. This includes, but is not limited to EKG monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Recovery Room Services related to IV sedation and/or local anesthesia

Plan will not provide reimbursement for a phase I or primary recovery room charged in connection with IV sedation or local anesthesia. Charges will be paid only if billed as a post procedure room or a phase II recovery (step-down) (e.g., arteriograms). The Anthem Rate shall not exceed the Facility’s average approved semi-private room and board rate as submitted to Anthem, less discount.

Routine Maternity Ultrasounds

- Two Routine Maternity Ultrasounds are considered for payment if the member has a benefit for the services. All other Routine Maternity Ultrasounds in excess of two (2) will be reviewed and recovered through a post audit process.
- The limitation (two) does not apply to Medically Necessary Maternity Ultrasounds as well as claims for the following providers; ER, Fetal Medicine and Radiologist
- Facilities are exempt at this time.

For more information click this link: OH: Medically necessary OB ultrasounds during pregnancy
Semi-Private Room Rate

Anthem must be notified in writing of any changes, and new rates will be loaded thirty (30) days after such notification. No Claims will be reprocessed as a result of changes to semi-private room rates. All eligible charges for Covered Services will be limited to the average approved semi-private room rate, less discount.

Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure.

Stand-by Charges

Standby equipment and consumable items such as oxygen, which are on standby, are not reimbursable. Only actual use is covered. Professional staff on standby is included in the reimbursement for the procedure and also is not separately reimbursable.

Stat Charges

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

Submission of Claim/Encounter Data

Facilities and Providers will submit Claims and encounter data to Anthem on a CMS-1500, UB04 or subsequent form, in a manner consistent with industry standards and policies and procedures as approved by Anthem. Anthem will make best efforts to pay all complete and accurate Claims for Covered Services submitted by Facilities and Providers in accordance with the applicable state statute, exclusive of Claims that have been suspended due to the need to determine Medical Necessity, to the extent of our payment liability, if any, because of issues such as coordination of benefits, subrogation or verification of coverage.

Plan will make such determinations within a reasonable period of time and will cooperate with Facilities, upon request, in good faith and within reason, in creating and maintaining methods and procedures to allow Plan to efficiently identify covered services.

Telemetry

Telemetry charges in emergency room ("ER") and intensive care unit ("ICU") or telemetry unit are included in the reimbursement for the place of service. Additional monitoring charges are not reimbursable. Separately billed telemetry charges will only be paid if observation ("OBS") charges do not exceed approved average semi-private room and board rate.

Test or Procedures Prior to Admission(s) or Outpatient Services

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/pre-operative testing:
254 – Drugs incident to other diagnostic services
255 – Drugs incident to radiology
30X – Laboratory
31X – Laboratory pathological
32X – Radiology diagnostic
341 – Nuclear medicine, diagnostic
35X – CT scan
40X – Other imaging services
46X – Pulmonary function
48X – Cardiology
53X – Osteopathic services
61X – MRI
62X – Medical/surgical supplies, incident to radiology or other services
73X – EKG/ECG
74X – EEG
92X – Other diagnostic services

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

Time Calculation

- Operating Room (“O.R.”) – O.R. time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse’s notes.
- Anesthesia – Time charges should be calculated from the start and finish times as documented on the anesthesia record. Anesthesia materials may be charged individually as used or included in a charge based on time. A charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, and IV sedation, must be billed at an appropriate rate for the lower level of anesthesia services.
- Recovery Room – Time should be calculated from the time the patient enters the recovery room until the patient leaves the recovery room as documented on the post anesthesia care unit record.
- Post Recovery Room – Time charges should be calculated from the time the patient leaves the recovery room until discharge. Charges are not to exceed the approved average semi-private room rate.

Undocumented or Unsupported Charges

Per Anthem policy, Plan will not reimburse charges that are not documented on medical records or supported with reasonable documentation.

Video Equipment used in Operating Room

Charges for video equipment used in a surgery are included in the reimbursement for the procedure and are not separately reimbursable. Charges such as batteries, covers, film, anti-fogger solution, and tapes are not separately reimbursable.

Additional Reimbursement Policies and Procedures

MyAnthem currently remains your source for reimbursement policies. Access MyAnthem exclusively via the Availity Web Portal. If you are a registered Availity user, log into Availity, select the More menu. My Payer Portals, and Provider Portal (Anthem) link. Select “I Agree” to link out to MyAnthem. A separate internet browser window will open to take you to MyAnthem. On MyAnthem select the Administrative Support tab, and view Procedures for Professional or Facility Reimbursement.

If you do not have an Availity user ID and Password, contact your organization’s Availity Access Administrator. If your organization is not registered for Availity, go to www.availity.com and select the link to register.

NOTE: This content will be available directly on Availity Web Portal in the future. Please watch for communication updates.

Medical Policies and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, “Medical Policy”) for Anthem. The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements, or clinical indications for certain new medical services and/or procedures, or for new uses of existing services and/or procedures.

The Medical Policy & Technology Assessment Committee (“MPTAC”) is the authorizing body for Medical Policy which serves as a basis for coverage decisions. MPTAC is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting memberships includes external physicians in clinical practices and participating in networks; external physicians in academic practices and participating in networks; internal medical directors and Chairs of MPTAC Subcommittees.
Additional detail about the Medical Policy development process, including information about the MPTAC and its Subcommittees, is provided in ADMIN.00001 Medical Policy Formation.

**Medical Policy and Clinical Utilization Management ("UM") Guidelines Distinction**

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the Medical Necessity of new services and/or procedures and new applications of existing services and/or procedures, while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services. In addition, medical policies are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the local Anthem Plan discretion.

Medical Policies and Clinical UM Guidelines are posted online at anthem.com

All Anthem Medical Policy is publicly available on our website, which provides transparency for Providers and Facilities, Covered Individuals and the public in general. Some vendor guidelines used to make coverage determinations are proprietary and are not publicly available on the Anthem website, but are available upon request.

To locate Medical Policy online, go to anthem.com. Select Menu and then under the Support heading select the Providers. Choose Ohio from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Medical Policies, Clinical UM Guideline, and Pre-Cert Requirements”. (Please note medical policies are available for Local Plan members as well as BlueCard/Out-of-area members.)

**Clinical UM Guidelines for Local Plan members**

The clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan or line of business may choose whether to implement a particular clinical UM guideline. The link below can be used to confirm whether or not the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by Ohio, navigate to the Disclaimer page by following the instructions above; scroll to the bottom of the page. Above the “Continue” button, select on the link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Ohio.”

**Utilization Management**

**Utilization Management Program**

Providers and Facilities agree to abide by the following Utilization Management ("UM") Program requirements in accordance with the terms of the Agreement and the Covered Individual’s Health Benefit Plan. Providers and Facilities agree to cooperate with Anthem in the development and implementation of action plans arising under these programs. Providers and Facilities agree to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

**Pre-service Review & Continued Stay Review**

A. Provider or Facility shall ensure that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Plan are submitted for review as soon as possible before the service occurs. Information provided to the Plan shall include demographic and clinical information; including, but not limited to, primary diagnosis.

B. Provider or Facility shall provide confirmation to Anthem UM with the demographic information and primary diagnosis within twenty-four (24) hours or next Business Day of a Covered Individual’s admission for scheduled procedures.
C. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within twenty-four (24) hours or the first Business Day following admission. Information provided to the Plan shall include demographic and clinical information, including, but not limited to, primary diagnosis.

D. Provider or Facility shall verify that the Covered Individual's primary care physician has provided a referral as required by certain Health Benefit Plans.

E. Provider or Facility shall comply with all requests for medical information for Continued Stay Review required to complete Plan's review and discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.

F. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting customer service.

Medical Policies and Clinical UM Guidelines

Please refer to the Medical Policies and Clinical Utilization Management (UM) Guidelines section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Review

If Plan maintains an on-site Initial Request/Continued Stay Review program, the Facility's UM program staff is responsible for following the Covered Individual's stay and documenting the prescribed plan of treatment, promoting the efficient use of services and resources, and facilitating available alternative outpatient treatment options. Facility agrees to cooperate with Anthem and provide Anthem with access to Covered Individuals medical records as well as access to the Covered Individuals in performing on-site Initial Request/Continued Stay Review and discharge planning related to, but not limited to the following:

- Emergency and/or maternity admissions
- Ambulatory surgery
- Case management
- Preadmission testing ("PAT")
- Inpatient Services, including Neo-natal Intensive Care Unit ("NICU")
- Focused procedure review

Discharge Planning

Discharge planning includes the coordination of medical services and supplies, medical personnel and family to facilitate the Covered Individual's timely discharge to a more appropriate level of care following an inpatient admission.

Observation Bed Policy

Please refer to the "Observation Services Policy" located in the Billing and Reimbursement Guidelines section of the Manual.

Retrospective Utilization Management

Retrospective UM is designed to review post service Claims for Health Services in accordance with the Covered Individual's Health Benefit Plan and Anthem medical policy and clinical guidelines. Medical records and pertinent information regarding the Covered Individual's care may be reviewed by health care professionals with review by peer clinical reviewers when necessary to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

Failure to Comply With Utilization Management Program

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

Case Management

Case Management is a voluntary Covered Individual Health Benefit Plan management program designed to support the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care, while maintaining or improving the quality of care delivered. The nurse case manager in Anthem’s case management program works with the treating physician(s), the Covered Individual and/or the Covered Individual’s Authorized Representative, and appropriate Facility personnel to both identify candidates for case management, and to coordinate benefits for alternative treatment settings. The program requires the consent and cooperation of the Covered Individual or Covered Individual’s Authorized Representative, as well as collaboration with the treating physicians.

A Covered Individual (or Covered Individual’s Authorized Representative) may self-refer or a Provider or Facility may refer a Covered Individual to Anthem’s Case Management program by calling the Customer Service number on the back of the member’s ID card.

Utilization Statistics Information

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. These may include, but are not limited to:
- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- Value of test requested or any other pertinent information Anthem deems necessary.

This information will be provided by Provider or Facility to Anthem at no charge to Anthem.

Electronic Data Exchange

Facility will support Anthem by providing electronic data exchange including, but not limited to, ADT (Admissions, Discharge and Transfer), daily census, confirmed discharge date and other relevant clinical data.

Reversals

Utilization Management determinations may be reversed if;

1. New information is received that is relevant to an adverse determination which was not available at the time of the determination, or;

2. The original information provided to support a favorable determination was incorrect, fraudulent, or misleading.

Peer to Peer Review Process

Upon the Providers request from an attending, treating or ordering physician, Anthem provides a medical peer-to-peer review process where our internal peer clinical reviewers re-examine cases when an adverse medical necessity determination will be made or has been made regarding health care services for Covered Individuals. The attending, treating or ordering physician may offer additional information and/or further discuss his/her cases with our peer clinical reviewers who made the initial adverse determination.

Initiating a Peer-to-Peer Request: Providers can initiate a peer-to-peer request IF he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any adverse medical necessity determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.
Quality of Care Incident

Providers and Facilities will notify Anthem in the event there is a quality of care incident that involves a Covered Individual.

Audits/Records Requests

At any time Anthem may request on-site, electronic or hard copy medical records, utilization review sheets and/or itemized bills related to Claims for the purposes of conducting audits and reviews to determine Medical Necessity, diagnosis and other coding and documentation of services rendered.

UM Definitions

1. **Pre-service Review.** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Covered Individual.

2. **Initial Request/Continued Stay Review.** Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.

3. **Pre-certification/Pre-authorization Request.** For Anthem UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to Anthem UM prior to service delivery.

4. **Pre-certification/Pre-authorization Requirements.** List of procedures that require Pre-service Review by Anthem UM prior to service delivery.

5. **Business Day.** Monday through Friday, excluding designated company holidays.

6. **Notification.** The telephonic and/or written/electronic communication to the applicable health care Providers, Facility and the Covered Individual documenting the decision, and informing the health care Providers and Facility and Covered Individual of their rights if they disagree with the decision.

Specific Clinical UM Guidelines

Specific clinical UM guidelines are available at www.Anthem.com.

- Select **Menu**, and then under the **Support** heading select the **Providers** link.
- Choose **your state** from the drop down list, and press **Enter**.
- Select the **Provider Home** tab at the top of the page.
- On the Provider Home Page, select Anthem Medical Policies and Clinical UM Guidelines under Self-Service and Support

Note: You can also access this information for local and BlueCard Out-of-Area members by selecting the Medical Policy, Clinical UM Guidelines, and Precert Requirements tout on the left side of all screens.

**E-Review**

E-Review is a web based tool that allows providers, clinics, and facilities to communicate their requests for services via a secured HIPAA compliant email to and from the associates of the Medical Management departments of Anthem.

E-Review can be used for:

- Precertification and Concurrent Review
- Predeterminations
- Retrospective Review
- Behavior Health Review
Interactive Care Reviewer (ICR)

Anthem’s Interactive Care Reviewer (ICR) is the preferred method for the submission of pre-authorization requests offering a streamlined and efficient experience for providers requesting inpatient and outpatient medical or behavioral health services for members covered by Anthem plans. Additionally, providers can use this tool to make inquiries on previously submitted requests regardless of how they were sent (phone, fax, ICR or other online tool).

- **Initiate pre-authorization requests online**, eliminating the need to fax. ICR allows detailed text, photo images and attachments to be submitted along with your request.
- **Make inquiries** on previously submitted requests via phone, fax, ICR or other online tool.
- **Instant accessibility** from almost anywhere including after business hours.
- **Utilize the dashboard** to provide a complete view of all UM Requests with real time status updates including email notifications if requested using a valid email address.
- **Real time** decisions for some common procedures.
- **Access ICR** under Authorizations and Referrals via the Availity Web Portal.

To register for an ICR webinar use the attached link: [ICR Webinar](#)

For an optimal experience with **Anthem’s Interactive Care Reviewer (ICR)** use a browser that supports 128-bit encryption. This includes Internet Explorer, Chrome, Firefox or Safari.

**Anthem’s Interactive Care Reviewer (ICR)** is not currently available for the following:

- FEP Members
- BlueCard®
- Some National Account Members
- Transplant services
- Services administered by vendors such as AIM Specialty HealthSM and OrthoNet LLC. *(For these requests, follow the same pre-authorization process that you use today.)*

Our website will be updated as additional functionality and lines of business are added throughout the year.

**Services Medically Managed by AIM Specialty HealthSM (AIM)**

Ordering providers can initiate precertification requests for members whose benefits include programs that are medically managed by AIM Specialty HealthSM online. Services include:

- Echocardiography
- Specialty pharmacy
- Radiation therapy
- Sleep studies
- Sleep therapy/treatment

Access online precertification via Availity® at [www.availity.com](http://www.availity.com) or the AIM Specialty HealthSM Website at [www.aimspecialtyhealth.com](http://www.aimspecialtyhealth.com).

Clinical guidelines can be accessed on AIM’s home page at [www.aimspecialtyhealth.com](http://www.aimspecialtyhealth.com) or online by selecting Anthem Medical Policies and Clinical UM Guidelines under Self-Service and Support.

Additional tools including a Quick Reference Guide, that will provide direction, CPT and HCPCS code and drug lists on the secure AIM provider portal can be found on our public website by clicking on the “Precertification” link under “Self-Service and Support” on the Provider Home Page.
Credentialing

Credentialing Scope

A. Professional Practitioners:

1. Practitioner Types: Anthem credentials the following health care practitioners, when an independent relationship exists between Anthem and the Practitioner, or the individual Practitioner is listed individually in Anthem’s provider network directory, and exclusions in section 2 (see below) do not apply:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry
- Chiropractors
- Optometrists providing Health Services covered under the Health Benefits Plan
- Oral and Maxillofacial surgeons
- Psychologists who are state certified or licensed and have doctoral or master’s level training
- Clinical social workers who are state certified or state licensed and have master’s level training
- Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master’s level training
- Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently
- Telemedicine practitioners who have an independent relationship with Anthem and who provide Treatment services under the Health Benefits Plan
- Medical therapists (e.g., physical therapists, speech therapists, and occupational therapists)
- Licensed Genetic Counselors who are licensed by the state to practice independently
- Audiologists who are licensed by the state to practice independently
- Acupuncturists (non-MD/DO) who are licensed, certified or registered by the state to practice independently
- Nurse practitioners Certified nurse midwives who are licensed, certified or registered by the state to practice independently
- Physician Assistants (as required locally)

2. Practitioners with whom we have a contractual relationship do not require credentialing when the Practitioner:

- Practices exclusively in an inpatient setting and provides care for Anthem Covered Individuals only because Covered Individuals are directed to the hospital or another inpatient setting; OR
- Practices exclusively in free-standing facilities and provides care for Anthem Covered Individuals only because Covered Individuals are directed to the facility.

Examples of this type of Practitioner include, but are not limited to:

- Pathologists
- Radiologists
- Anesthesiologists
- Neonatologists
- Emergency Room Physicians
- Urgent Care Center Physicians
- Urgent Care Center mid-level providers (e.g. nurse practitioners, physician assistants)
- Hospitalists
- Pediatric Intensive Care Specialists
- Other Intensive Care Specialists
3. The following behavioral health practitioners are not subject to professional conduct and competence review under Anthem’s credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:
   - Certified Behavioral Analysts
   - Certified Addiction Counselors
   - Substance Abuse Practitioners

Note: an individual who is contracted and practices in the office setting must be credentialed when that practitioner meets criteria in section 2 of this Credentialing Policy, above.

B. Health Delivery Organizations (“HDOs”)

1. Anthem credentials the following Health Delivery Organizations (“HDOs”):
   - Hospitals
   - Home Health Agencies
   - Skilled Nursing Facilities
   - Nursing Homes
   - Ambulatory Surgical Centers
   - Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings, including:
     - Adult Family Care/Foster Care Homes
     - Ambulatory Detox
     - Community Mental Health Centers (CMHC)
     - Crisis Stabilization Units
     - Intensive Family Intervention Services
     - Intensive Outpatient – Mental Health and/or Substance Abuse
     - Methadone Maintenance Clinics
     - Outpatient Mental Health Clinics
     - Outpatient Substance Abuse Clinics
     - Partial Hospitalization – Mental Health and/or Substance Abuse
     - Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse
   - Birthing Centers
   - Convenient Care centers/Retail Health Clinics/Walk-In Clinics
   - Intermediate Care Facilities
   - Urgent Care Centers
   - Federally Qualified Health Centers (FQHC)
   - Home Infusion Therapy when not associated with another currently credentialed HDO
   - Rural Health Clinics

2. The following Health Delivery Organizations are not subject to professional conduct and competence review under Anthem’s credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:
   - Clinical laboratories (a CMS-issued CLIA certificate or a hospital based exemption from CLIA)
   - End Stage Renal Disease (ESRD) service providers (dialysis facilities)
   - Portable x-ray Suppliers
   - Home Infusion Therapy when associated with another currently credentialed HDO

Credentials Committee

The decision to accept, retain, deny or terminate a practitioner’s participation in a Network or Plan Program is conducted by a peer review body, known Anthem’s Credentials Committee (“CC”).

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC
members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair’s discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

The CC will access various specialists for consultation, as needed to complete the review of a practitioner’s credentials. A committee member will disclose and abstain from voting on a practitioner if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioner; or (ii) feels his or her judgment might otherwise be compromised. A committee member will also disclose if he or she has been professionally involved with the practitioner. Determinations to deny an applicant’s participation, or terminate a practitioner from participation in one or more Networks or Plan Programs, require a majority vote of the voting members of the CC in attendance, the majority of whom are Network practitioners.

During the credentialing process, all information that is obtained is highly confidential. All CC meeting minutes and practitioner files are stored in locked cabinets and can only be seen by appropriate Credentialing staff, medical directors, and CC members. Documents in these files may not be reproduced or distributed, except for confidential peer review and credentialing purposes; and peer review protected information will not be shared externally.

Practitioners and HDOs are notified that they have the right to review information submitted to support their credentialing applications. This right includes access to information obtained from any outside sources with the exception of references, recommendations or other peer review protected information. Providers are given written notification of these rights in communications from Anthem which initiates the credentialing process. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner or HDO within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented in the practitioner’s credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. Upon request, applicant will be provided with the status of his or her credentialing application. Written notification of this right may be included in a variety of communications from Anthem which includes the letter which initiates the credentialing process, the provider web site, or Provider Manual. When such requests are received, providers will be notified whether the credentialing application has been received, how far in the process it has progressed and a reasonable date for completion and notification. All such requests will be responded to verbally unless the provider requests a written response.

Anthem may request and will accept additional information from the applicant to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC will review the information and rationale presented by the applicant to determine if a material omission has occurred or if other credentialing criteria are met.

Nondiscrimination Policy

Anthem will not discriminate against any applicant for participation in its Networks or Plan Programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not
discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner or HDO must complete a standard application form when applying for initial participation in one or more of Anthem’s Networks or Plan Programs. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”), a Universal Credentialing Datasource is utilized. CAQH built the first national provider credentialing database system, which is designed to eliminate the duplicate collection and updating of provider information for health plans, hospitals and practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.

Anthem will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Anthem will review verification of the credentialing data as described in the following tables unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

A. Practitioners

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

B. HDOs

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

The recredentialing process incorporates re-verification and the identification of changes in the practitioner’s or HDO’s licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the practitioner’s or HDO’s professional conduct and competence. This information is reviewed in order to assess whether practitioners and HDOs continue to meet Anthem credentialing standards.

During the recredentialing process, Anthem will review verification of the credentialing data as described in the tables under Initial Credentialing unless otherwise required by regulatory or accrediting bodies. These tables represent minimum requirements.

All applicable practitioners and HDOs in the Network within the scope of Anthem Credentialing Program are required to be recredentialed every three (3) years unless otherwise required by contract or state regulations.

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, all Network HDOs are required to maintain accreditation by an appropriate, recognized accrediting body or, in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or a site survey performed by a designated independent external entity within the past 36 months for that HDO.

Recredentialing of HDOs occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Networks or Plan Programs must submit all required supporting documentation.

On request, HDOs will be provided with the status of their credentialing application. Anthem may request, and will accept, additional information from the HDO to correct incomplete, inaccurate, or conflicting credentialing information. The CC will review this information and the rationale behind it, as presented by the HDO, and determine if a material omission has occurred or if other credentialing criteria are met.

Ongoing Sanction Monitoring

To support certain credentialing standards between the recredentialing cycles, Anthem has established an ongoing monitoring program. Credentialing performs ongoing monitoring to help ensure continued compliance with credentialing standards and to assess for occurrences that may reflect issues of substandard professional conduct and competence. To achieve this, the credentialing department will review periodic listings/reports within thirty (30) calendar days of the time they are made available from the various sources including, but not limited to, the following:

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management ("OPM")
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments
6. Clinical Quality Management Department (including data regarding complaints of both a clinical and non-clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem Departments
8. Any other verified information received from appropriate sources

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response including, but not limited to: review by the Chair of Anthem CC, review by the Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report practitioners or HDOs to the appropriate authorities as required by law.
Appeals Process

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem’s Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat Network practitioners and HDOs, as well as those applying participation fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating participation in Anthem’s Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank (“NPDB”). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner’s or HDO’s participation in one or more of Anthem’s Networks or Plan Programs and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate terminations may be imposed due to the practitioner’s or HDO’s suspension or loss of licensure, criminal conviction, or Anthem’s determination that the practitioner’s or HDO’s continued participation poses an imminent risk of harm to Covered Individuals. A practitioner/HDO whose license has been suspended or revoked has no right to informal review/reconsideration or formal appeal.

Reporting Requirements

When Anthem takes a professional review action with respect to a practitioner’s or HDO’s participation in one or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board. The credentialing staff will comply with all state and federal regulations in regard to the reporting of adverse determinations relating to professional conduct and competence. These reports will be made to the appropriate, legally designated agencies. In the event that the procedures set forth for reporting reportable adverse actions conflict with the process set forth in the current NPDB Guidebook and, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

Initial applicants must meet the following criteria in order to be considered for participation:

A. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP; and
B. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals; and
C. Possess a current, valid, and unrestricted Drug Enforcement Agency ("DEA") and/or Controlled Dangerous Substances ("CDS") registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS registration for each state.

Initial applications should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the CC:

A. For MDs, DOs, DPMs and oral and maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties ("ABMS"), American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada ("RCPSC"), College of Family Physicians of Canada ("CFPC"), American Board of Podiatric Surgery ("ABPS"), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS") in the clinical discipline for which they are applying.
B. Individuals will be granted five years or a period of time consistent with ABMS board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.

C. Individuals with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement.

D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.

1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
   a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC) in the clinical specialty or subspecialty for which they are applying which has now expired AND a minimum of ten (10) consecutive years of clinical practice. OR
   b. Training which met the requirements in place at the time it was completed in a specialty field prior to the availability of board certifications in that clinical specialty or subspecialty. OR
   c. Specialized practice expertise as evidenced by publication in nationally accepted peer review literature and/or recognized as a leader in the science of their specialty AND a faculty appointment of Assistant Professor or higher at an academic medical center and teaching Facility in Anthem Network AND the applicant’s professional activities are spent at that institution at least fifty percent (50%) of the time.

2. Practitioners meeting one of these three (3) alternative criteria (a, b, c) will be viewed as meeting all Anthem education, training and certification criteria and will not be required to undergo additional review or individual presentation to the CC. These alternatives are subject to Anthem review and approval. Reports submitted by delegate to Anthem must contain sufficient documentation to support the above alternatives, as determined by Anthem.

E. For MDs and DOs, the applicant must have unrestricted hospital privileges at a The Joint Commission (“TJC”), National Integrated Accreditation for Healthcare Organizations (“NIAHO”), an AOA accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network/practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)
   1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
   2. Application attestation signed date within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;
   3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
   4. No evidence of potential material omission(s) on application;
   5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;
   6. No current license action;
   7. No history of licensing board action in any state;
   8. No current federal sanction and no history of federal sanctions (per System for Award Management (SAM), OIG and OPM report nor on NPDB report);
   9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS registration for each applicable state.
Initial applicants who have NO DEA/CDS registration will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he/she has applied for a DEA/CDS registration, the credentialing process may proceed if all of the following are met:

a. It can be verified that this application is pending.

b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.

c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.

d. Anthem will verify the appropriate DEA/CDS registration via standard sources.
   
   i. The applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network.
   
   ii. Initial applicants who possess a DEA/CDS registration in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA/CDS registration. If the applicant has applied for additional DEA/CDS registration the credentialing process may proceed if ALL the following criteria are met:

      a. It can be verified that this application is pending and,
      
      b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA/CDS registration is obtained.
      
      c. The applicant agrees to notify Anthem upon receipt of the required DEA/CDS registration.
      
      d. Anthem will verify the appropriate DEA/CDS registration via standard sources; applicant agrees that failure to provide the appropriate DEA/CDS registration within a ninety (90) calendar day timeframe will result in termination from the Network,

      AND

      e. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs: Medicare, Medicaid or FEHBP.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;

11. No history of or current use of illegal drugs or history of or current alcoholism;

12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.

13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two (2) years.

14. No history of criminal/felony convictions or a plea of no contest;

15. A minimum of the past ten (10) years of malpractice case history is reviewed.

16. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem’s Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs and oral and maxillofacial surgeons;

17. No involuntary terminations from an HMO or PPO;

18. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:

   a. investment or business interest in ancillary services, equipment or supplies;
   
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   
   c. voluntary surrender of state license related to relocation or nonuse of said license;
   
   d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
   
   e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   
   f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;

h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

Note: the CC will individually review any practitioner that does not meet one or more of the criteria required for initial applicants.

Practitioners who meet all participation criteria for initial or continued participation and whose credentials have been satisfactorily verified by the Credentialing department may be approved by the Chair of the CC after review of the applicable credentialing or recredentialing information. This information may be in summary form and must include, at a minimum, practitioner’s name and specialty.

B. Currently Participating Applicants (Recredentialing)

1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;

2. Re-credentialing application signed dated within one hundred eighty (180) calendar days of the date of submission to the CC for a vote;

3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;

4. No evidence of potential material omission(s) on re-credentialing application;

5. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP. If, once a Practitioner participates in the Anthem's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as the Anthem's other credentialed provider Network(s).

6. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;

7. *No current license probation;

8. *License is unencumbered;

9. No new history of licensing board reprimand since prior credentialing review;

10. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);

11. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;

12. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/practitioner of similar specialty at a Network HDO who provides inpatient care to Covered Individuals needing hospitalization;

13. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;

14. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;

15. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;

16. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.

17. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;

18. No new (since previous credentialing review) “yes” answers on attestation/disclosure questions with exceptions of the following:

   a. investment or business interest in ancillary services, equipment or supplies;
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. voluntary surrender of state license related to relocation or nonuse of said license;
   d. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window;
g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

19. No QI data or other performance data including complaints above the set threshold.

20. Recredentialed at least every three (3) years to assess the practitioner’s continued compliance with Anthem standards.

*It is expected that these findings will be discovered for currently credentialed Network practitioners and HDOs through ongoing sanction monitoring. Network practitioners and HDOs with such findings will be individually reviewed and considered by the CC at the time the findings are identified.

Note: the CC will individually review any credentialed Network Practitioners and HDOs that do not meet one or more of the criteria for recredentialing.

C. Additional Participation Criteria and Exceptions for Behavioral Health practitioners (Non Physician) Credentialing.

1. Licensed Clinical Social Workers (“LCSW”) or other master level social work license type:
   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education (“CSWE”) or the Canadian Association on Social Work Education (“CASWE”).
   b. Program must have been accredited within three (3) years of the time the practitioner graduated.
   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education Accreditation (“CHEA”). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor (“LPC”) and marriage and family therapist (“MFT”) or other master level license type:
   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs (“CACREP”), or Commission on Accreditation for Marriage and Family Therapy Education (“COAMFTE”) listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.
   d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and:
   e. Licensure to practice independently.

3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited
by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of
the practitioner’s graduation.

b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.

c. Certification by the American Nurses Association (“ANA”) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.

d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Covered Individuals.

4. Clinical Psychologists:
   a. Valid state clinical psychologist license.
   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner’s graduation.
   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
   d. Master’s level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:
   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (“ABPN”) or American Board of Clinical Neuropsychology (“ABCN”).
   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
   c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
      i. Transcript of applicable pre-doctoral training OR
      ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
      iii. Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
      iv. Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week

6. Licensed Psychoanalysts:
   a. Applies only to Practitioners in states that license psychoanalysts.
   b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
   c. Practitioner must possess a valid psychoanalysis state license.
      i. Practitioner shall possess a master’s or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
      ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
         a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the
licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.

c) Meet examination requirements for licensure as determined by the licensing state.


1. Process, requirements and Verification – Nurse Practitioners:

a. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.

b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.

c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.

d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:

i. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm); or

ii. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org); or

iii. National Certification Corporation (http://www.nccwebsite.org); or

iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (http://www.pncb.org/ptistore/control/exams/ac/progs); OR

v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (http://oncc.org); This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by the Anthem is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.

g. The NP applicant will undergo the standard credentialing processes outlined in the Anthem’s Credentialing Policies. NPs are subject to all the requirements outlined in
these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

h. Upon completion of the credentialing process, the NP may be listed in the Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.

i. NPs will be clearly identified as such:
   i. On the credentialing file;
   ii. At presentation to the Credentialing Committee; and
   iii. On notification to Network Services and to the provider database.

2. Process, Requirements and Verifications – Certified Nurse Midwives:
   a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
   b. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All CNM applicants will be certified by either:
      i. The National Certification Corporation for Ob/Gyn and Neonatal Nursing;
      or
      ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwifes.
      This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by the Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.
   f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
   g. The CNM applicant will undergo the standard credentialing process outlined in the Anthem’s Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
   h. Upon completion of the credentialing process, the CNM may be listed in the Anthem provider directories. As with all providers, this listing will accurately reflect
their specific licensure designation and these providers will be subject to the audit process.

i. CNMs will be clearly identified as such:
   i. On the credentialing file;
   ii. At presentation to the Credentialing Committee; and
   iii. On notification to Network Services and to the provider database.

3. Process, Requirements and Verifications – Physician’s Assistants (PA):
   a. The PA applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
   b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.
   c. The license status must be that of PA as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
   d. If the PA has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal company procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
   e. All PA applicants will be certified by the National Commission on Certification of Physician’s Assistants. This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by the Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be classified as a Level II according to geographic Credentialing Policy #8 and submitted for individual review by the Credentialing Committee.
   f. If the PA has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the PA will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
   g. The PA applicant will undergo the standard credentialing process outlined in the Anthem’s Credentialing Policies. PAs are subject to all the requirements described in these Credentialing Policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
   h. Upon completion of the credentialing process, the PA may be listed in the Anthem provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
   i. PA’s will be clearly identified such:
      i. On the credentialing file;
      ii. At presentation to the Credentialing Committee; and
      iii. On notification to Network Services and to the provider database.

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare or the appropriate state oversight agency or site survey performed by a designated independent external entity within the past 36 months. Non-accredited HDOs are subject to individual review by the CC and will be considered for Covered Individual access need only when the CC review indicates compliance with Anthem standards and there are no deficiencies noted on the Medicare or state oversight review which would adversely affect quality or care or patient safety. HDOs are recredentialed at least every
three (3) years to assess the HDO’s continued compliance with Anthem standards.

A. General Criteria for HDOs:
1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in the Anthem’s programs or provider Network(s), exclusion from Medicare, Medicaid or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as the Anthem’s other credentialed provider Network(s).
4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS state site or a designated independent external entity survey for review by the CC to determine if Anthem’s quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

**HDO Type and Anthem Approved Accrediting Agent(s)**

**MEDICAL FACILITIES**

<table>
<thead>
<tr>
<th>Facility Type (Medical Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital</td>
<td>CIQH, CTEAM, DNV/NIAHO, HFAPTJC</td>
</tr>
<tr>
<td>Ambulatory Surgical Centers</td>
<td>AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Birthing Center</td>
<td>AAAHC, CABC</td>
</tr>
<tr>
<td>Clinical Laboratories</td>
<td>CLIA, COLA</td>
</tr>
<tr>
<td>Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)</td>
<td>DNV/NIAHO, UCAOA, TJC</td>
</tr>
<tr>
<td>Dialysis Center</td>
<td>CMS Certification, TJC</td>
</tr>
<tr>
<td>Federally Qualified Health Center (FQHC)</td>
<td>AAAHC</td>
</tr>
<tr>
<td>Free-Standing Surgical Centers</td>
<td>AAAASF, AAPSF, HFAP, IMQ, TJC</td>
</tr>
<tr>
<td>Home Health Care Agencies (HHA)</td>
<td>ACHC, CHAP, CTEAM, DNV/NIAHO, TJC</td>
</tr>
<tr>
<td>Home Infusion Therapy (HIT)</td>
<td>ACHC, CHAP, CTEAM, HQAA, TJC</td>
</tr>
<tr>
<td>Hospice</td>
<td>ACHC, CHAP, TJC</td>
</tr>
<tr>
<td>Intermediate Care Facilities</td>
<td>CTEAM</td>
</tr>
<tr>
<td>Portable x-ray Suppliers</td>
<td>FDA Certification</td>
</tr>
<tr>
<td>Skilled Nursing Facilities/Nursing Homes</td>
<td>BOC INTL, CARF, TJC</td>
</tr>
<tr>
<td>Rural Health Clinic (RHC)</td>
<td>AAAASF, CTEAM, TJC</td>
</tr>
<tr>
<td>Urgent Care Center (UCC)</td>
<td>AAAHC, IMQ, TJC, UCAOA</td>
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**Behavioral Health**

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital—Psychiatric Disorders</td>
<td>CTEAM, DNV/NIAHO, TJC, HFAP</td>
</tr>
<tr>
<td>Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation</td>
<td>HFAP, NIAHO, TJC</td>
</tr>
<tr>
<td>Adult Family Care Homes (AFCH)</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Adult Foster Care</td>
<td>ACHC, TJC</td>
</tr>
<tr>
<td>Community Mental Health Centers (CMHC)</td>
<td>AAAHC, CARF, CHAP, COA, HFAP, TJC</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td>TJC</td>
</tr>
<tr>
<td>Intensive Family Intervention Services</td>
<td>CARF</td>
</tr>
<tr>
<td>Intensive Outpatient – Mental Health and/or Substance Abuse</td>
<td>ACHC, DNV/NIAHO, TJC, COA, CARF</td>
</tr>
<tr>
<td>Outpatient Mental Health Clinic</td>
<td>HFAP, TJC, CARF, COA</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse</td>
<td>CARF, DNV/NIAHO, HFAP, TJC, for programs associated with an acute care facility or Residential Treatment Facilities.</td>
</tr>
</tbody>
</table>
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital – Detoxification Only Facilities</td>
<td>DNV/NIAHO, HFAP, TJC</td>
</tr>
<tr>
<td>Behavioral Health Ambulatory Detox</td>
<td>CARF, TJC</td>
</tr>
<tr>
<td>Methadone Maintenance Clinic</td>
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Standards of Participation

Anthem contracts with many types of providers that do not require credentialing as described in the Credentialing section of this manual. However, to become a Network/Participating Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, the chart below outlines requirements that must be met in order to be considered for contracting as a Network/Participating Provider or Facility in one of these specialties:

TJC – The Joint Commission, CHAP – Community Health Accreditation Program, ACHC - Accreditation Commission for Health Care, CLIA - Clinical Laboratory Improvement Amendments, HQAA – Healthcare Quality Association on Accreditation, ABC - The American Board for Certification in Orthotics, Prosthetics & Pedorthics, BOC - Board of Certification/Accreditation, NEBO- National Examining Board of Ocularists

Quality Improvement Program

Quality Improvement Program Overview

"Together, we are transforming health care with trusted and caring solutions." We believe health care is local, and Anthem has the strong local presence required to understand and meet customer needs. Our Plan is well-positioned to deliver what customers want: innovative, choice-based products; distinctive service; simplified transactions; and better access to information for quality care. Our local plan presence and broad expertise create opportunities for collaborative programs that reward Providers and Facilities for clinical quality and excellence. Facilities must cooperate with Quality Improvement activities. The Quality Improvement ("QI") Program. Our commitment to health improvement and care management provides added value to customers and health care professionals – helping improve both health and health care
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costs for those Anthem serves. Anthem takes a leadership role to improve the health of our communities and is helping to address some of health care’s most pressing issues. Providers and Description defines the quality infrastructure that supports Anthem’s QI strategies.

- The QI Program Description establishes QI Program governance, scope, goals, measurable objectives, structure, and responsibilities encompassing the quality of medical and behavioral health care and services provided to Covered Individuals.
- Annually, a QI Work Plan is developed and which reflects ongoing progress made on QI activities during the year. The QI Work Plan includes the Plan’s approach to patient safety and improving medical and behavioral health care: quality of clinical care, safety of clinical care, and quality of service.
- The QI Evaluation assesses outcomes of the Plan’s medical and behavioral health care programs, processes and activities. The QI Evaluation also evaluates how the quality Program goals and objectives were met.

Information on Anthem’s QI Program and most current outcomes can be found on, anthem.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from drop down list and enter. Select the Health & Wellness tab at the top of the page. Select Quality Improvements and Standards from the drop down list and select “Quality Improvement Program.”

Goals and Objectives

- The following QI Program goals and objectives have been adopted to support Anthem’s vision and values and to promote continuous improvement in quality care, patient safety and quality of service to Covered Individuals, Providers and Facilities:
  - To develop and maintain a well-integrated system to continuously identify, measure, assess, and help improve clinical and service quality outcomes through standardized and collaborative activities.
  - To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations including compliance with regulatory requirements, accreditation standards, and policies and procedures.
  - To promote processes that reduce medical errors and improve patient safety by implementing member-focused, practitioner/provider initiatives, and safety initiatives.
  - To identify the educational needs of Covered Individuals, practitioners, and other health care professionals including behavioral health practitioners and providers.
  - To identify health disparities trends for Covered Individuals based on key clinical quality metrics, evidence-based research, or Covered Individual experience metrics to inform response needs with appropriate culturally and linguistically enhanced services.
  - To help maximize health status, improve health outcomes, and reduce health care costs of Covered Individuals through effective Case Management and Disease Management programs addressing complex care needs.

As part of the QI Program, initiatives in these major areas include but are not limited to:

Quality and Safety of Clinical Care

- Chronic Disease and Prevention: Anthem focuses on Covered Individuals and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and COPD, and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set).

Case Management: A program designed to provide a comprehensive and integrated approach to early identification, appropriate treatment, intensive case management, and individualized recovery support for
members with complex, behavioral health conditions who are at risk for negative outcomes and high costs.

- **Community Health:** Anthem addresses public health priorities including behavioral health, cancer, diabetes, maternal/child health, obesity, patient safety, and smoking cessation by collaborating with key stakeholders in the industry. These focus areas are aligned with Anthem Foundation goals, measured through State Health Index (SHI) to assess performance trend and improvement opportunities. Programs recently developed include:
  - ‘Web-based resources for managers to support employees’ healthy return to work after cancer treatment. *(Work Plan Transitions for People Touched by Cancer)*
  - Smoking Cessation Program that helps to reduce smoking, as well as, premature and underweight births. *(Baby & Me - Tobacco Free)*
  - Digital magazine featuring free resources available to all people touched by cancer. *(Stronger Together)*
  - Diabetes program that promotes successful aging through lifelong learning, healthy living and social engagement in collaboration with the National Council on Aging (NCOA), the Oasis Institute, and YMCA. *(Better Choices Better Health)*

- **Disease Management:** The ConditionCare programs are designed to help maximize health status, improve health outcomes, and help reduce health care costs of Covered Individuals diagnosed with Asthma (pediatric and adult), Diabetes (Type 1 and Type 2, pediatric and adult), Coronary Artery Disease (CAD), Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD). These disease management programs were created and developed based on recent versions of nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two (2) years and program interventions and protocols are updated accordingly.

- **Health & Wellness:** Programs offer a seamless integration of preventive care, wellness, case management, and care coordination to meet the needs of Covered Individuals along the complete continuum of care. Programs include: MyHealth Coach (MHC), MyHealth Advantage (MHA), Neonatal Intensive Care Program, Worksite Wellness, and Healthy Lifestyles.

**Service Quality**

Anthem periodically surveys its Covered Individuals, evaluates service performance and quality of care, and strives to provide excellent service to Covered Individuals, Providers and Facilities. Anthem analyzes trends to identify service opportunities and recommends appropriate activities to address root causes.

**Patient Safety**

Patient safety is critical to the delivery of quality health care by Providers and Facilities. Our goal is to work with physicians, hospitals and other health care Providers and Facilities to promote and encourage patient safety and to help reduce medical errors through the use of guidelines, outcomes-based medicine, processes, and systems aimed at reducing errors. Specifically, we will provide support through collaborative efforts with physicians and hospitals for the medical and behavioral health care they provide to Covered Individuals that includes incentives based on quality metrics, public reporting of safety information to employers, Providers, Facilities, and Covered Individuals to emphasize the importance of programs to reduce medical errors, and empowerment of consumers with information to make informed choices. Improvement in patient safety is dependent upon not only patient needs, but also upon informed patients and the global health care community’s demand and attention to clinical outcomes-based practices.

**Member Rights and Responsibilities**

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

Continuity and Coordination of Care

Anthem encourages communication between all physicians, including primary care physicians (PCPs) and medical specialists, as well as other health care professionals who are involved in providing care to Anthem Covered Individuals. Please discuss the importance of this communication with each Covered Individual and make every reasonable attempt to elicit his or her permission to coordinate care at the time treatment begins. HIPAA allows the exchange of information between Covered Entities for the purposes of Treatment, Payment and Health Care Operations.

The Anthem QI Program is an ongoing, and integrative program, which features a number of evaluative surveys and improvement activities designed to help ensure the continuity and coordination of care across physician and other health care professional sites, enhancing the quality, safety, and appropriateness of medical and behavioral health care services offered by Providers.

Continuity of Care/Transition of Care Program

This program is for Covered Individuals when their Provider or Facility terminates from the network and new Covered Individuals (meeting certain criteria) who have been participating in active treatment with a provider not within Anthem’s network.

Anthem makes reasonable efforts to notify Covered Individuals affected by the termination of a Provider or Facility according to contractual, regulatory and accreditation requirements and prior to the effective termination date. Anthem also helps them select a new Provider or Facility.

Anthem will work to facilitate the Continuity of Care/Transition of Care (COC/TOC) when Covered Individuals, or their covered dependents with qualifying conditions, need assistance in transitioning to in-network Providers or Facilities. The goal of this process is to minimize service interruption and to assist in coordinating a safe transition of care. Completion of Covered Services may be allowed at an in-network benefit and reimbursement level with an out-of-network provider for a period of time, according to contractual, regulatory and accreditation requirements, when necessary to complete a course of treatment and to arrange for a safe transfer to an in-network Provider or Facility.

Completion of Covered Services by a Provider or Facility whose contract has been terminated or not renewed for reasons relating to medical disciplinary cause or reason, fraud or other criminal activity will not be facilitated.

Covered Individuals may contact Customer Care to get information on Continuity of Care/Transition of Care.

Quality – In – Sights® : Hospital Incentive Program (Q-HIP®)

The Quality-In-Sights®: Hospital Incentive Program (Q-HIP®) is our performance-based reimbursement program for hospitals. The mission of Q-HIP is to help improve patient outcomes in a hospital setting and promote health care value by financially rewarding hospitals for practicing evidence-based medicine and implementing best practices. Q-HIP strives to promote improvement in health care quality and to raise the bar by moving the bell shaped “quality curve” to the right towards high performance.

Q-HIP measures are credible, valid, and reliable because they are based on measures developed and endorsed by national organizations which may include:

- American College of Cardiology (ACC)
In order to align Q-HIP goals with national performance thresholds, the Q-HIP benchmarks and targets are based on national datasets such as the Centers for Medicare and Medicaid Services’ Hospital Compare database. The measures can be tracked and compared within and among hospital[s] for all patient data – regardless of health plan carrier.

Annual meetings are held with participating hospitals from across the country, offering participants an opportunity to share feedback regarding new metrics and initiatives. Additionally, a National Advisory Panel on Value Solutions (NAPVS) was established in 2009 to provide input during the scorecard development process. The NAPVS is made up of patient safety and quality leaders from health systems and academic medical centers from across the country and offers valuable advice and guidance as new measures are evaluated for inclusion in the program.

Participating hospitals are required to provide Anthem with data on measures outlined in the Q-HIP Manual. Q-HIP measures are based on commonly accepted indicators of hospitals’ quality of care. Participating hospitals will receive a copy of their individual scorecard which shows their performance on the Q-HIP measures.

Performance Data

Provider/Facility Performance Data means compliance rates, reports and other information related to the appropriateness, cost, efficiency and/or quality of care delivered by an individual healthcare practitioner, such as a physician, or a healthcare organization, such as a hospital. Common examples of performance data would include the Healthcare Effectiveness Data and Information Set (HEDIS) quality of care measures maintained by the National Committee for Quality Assurance (NCQA) and the comprehensive set of measures maintained by the National Quality Forum (NQF). Provider/Facility Performance Data may be used for multiple Plan programs and initiatives, including but not limited to:

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV) and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to shared savings programs, enhanced fee schedules and bundled payment arrangements.

- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

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**Overview of HEDIS®**

HEDIS (Healthcare Effectiveness Data and Information Set) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem’s HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and Anthem requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs. More information on HEDIS can be found online, at anthem.com. Select Menu, and under the Support heading select “Providers” link. Choose your state from the drop down list and enter. Select the Health & Wellness tab at the top of the page. Select “Quality Improvement and Standards” from the drop down list and then scroll down to “HEDIS Information”.

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Overview of CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem's Covered Individuals about their experiences with Anthem’s health plans in the past year. This includes the Covered Individual’s access to medical care and the quality of the services provided by Anthem’s network of Providers. Anthem analyzes this feedback to identify issues causing Covered Individual dissatisfaction and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

Health Plans report survey results to NCQA, which uses these survey results for the annual accreditation status determinations and to create National benchmarks for care and service. Health Plans also use CAHPS® survey data for internal quality improvement purposes.

Results of these surveys are shared with Providers annually via “Network Update” our provider newsletters found on Anthem’s Provider website at anthem.com, so they have an opportunity to learn how Anthem Covered Individuals feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients’ access to care and improve interpersonal skills to make the patient care experience a more positive one.

© CAHPS is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through the Internet. To access the guidelines, go to anthem.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list, and press Enter. Select the Provider Home tab at the top of the page. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled “Clinical Practice Guidelines.”

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the clinical practice guidelines.

Preventive Health Guidelines

Anthem considers prevention an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above
organizations make recommendations based on reasonable medical evidence. We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Covered Individuals.

The current guidelines are available on our website. To access the guidelines, go to anthem.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list, and press Enter. Select the Provider Home tab at the top of the page. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled “Preventive Health Guidelines”.

With respect to the issue of coverage, each Covered Individual should review his/her Certificate of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment. The Certificate of Coverage and/or Schedule of Benefits supersedes the preventive health guidelines.

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**Medical Record Standards**

Anthem recognizes the importance of medical record documentation in the delivery and coordination of quality care. Anthem has medical record standards that require Providers and Facilities to maintain medical records in a manner that is current, organized, and facilitates effective and confidential medical record review for quality purposes.

For more information on Medical Record standards, please go to anthem.com. Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list, and press Enter. Select the Provider Home tab at the top of the page. On the Provider home page under the Health and Wellness tab (on the blue toolbar), choose Quality Improvement and Standards, and then scroll down to “Medical Record Review”.

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**Cultural Diversity**

Cultural Diversity Overview
Anthem identifies health disparity trends for Covered Individuals based on key clinical quality metrics, evidence-based research, or member experience metrics and conducts research on best practices to help educate Providers, Facilities and others about how to reduce health disparities. Specifically, Anthem:

1. Monitors the quality of health care for actionable health and health care disparities trends
   a. Identifies clinical and geographic areas exhibiting health and health care disparities and designs appropriate interventions to help close the disparity gaps
   b. Establishes baseline data and measures/evaluates the results of program interventions
   c. Supports Covered Individual access to equitable treatment, standards of care and services based on their Plan benefits

2. Promotes Culturally and Linguistically Appropriate Services (“CLAS”)​
   a. Offers education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
   b. Facilitates cultural competency of Anthem associates to meet the Covered Individuals’ needs for culturally sensitive, linguistically appropriate care and service
c. Offers education, tools and subject matter expertise to Covered Individuals that may help them improve their health literacy, allowing better communication with their doctors and Anthem about their health care and service

3. Develops programs to help improve health status and outcomes
   a. Promotes consumer-centered care that addresses the Covered Individuals' values, needs and preferences in reaching optimal health care and outcomes standards
   b. Supports communities in which Anthem does business with cultural and linguistic programs and services
   c. Collaborates with other industry and government efforts to help reduce and eliminate health disparities

Anthem strives to promote the Department of Health and Human Services Office of Minority Health's National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (the National CLAS standards).  https://www.thinkculturalhealth.hhs.gov/clas/standards

**Learning Opportunities**

Anthem recognizes that Providers and Facilities can encounter challenges when delivering health care services to a diverse population. Those challenges arise when Providers and Facilities need to cross a cultural divide to treat patients who may have different behaviors, attitudes, and beliefs concerning health care.

In response, Anthem offers online educational experiences for providers – e.g., “Moving Toward Equity in Asthma Care.”

Built upon extensive research and data analytics, the experience offers 1 hour of Continuing Medical Education (“CME”) credit through the American Academy of Family Physicians, and includes scenarios that fulfill the following learning objectives:

- Describe common racial and ethnic asthma disparities – and their effects on diverse patients' ability to successfully control their asthma.
- Describe ways providers may unknowingly contribute to poor asthma care for diverse populations.
- Explain ways providers can improve the quality of asthma care to enhance outcomes among African Americans, Hispanic and Asian patients.
- Explain the importance of using spirometry to assess the severity of asthma accurately.
- Explain the concept of “unconscious bias.”

A “Resources” section contains additional information on asthma disparities, as well as culturally relevant asthma materials to print and share with diverse patients.

The experience was developed in an effort to address the substantial gaps in asthma care and outcomes for diverse populations.

Primary Audiences include: Physicians (Family Practice, Pediatrician, Pulmonologist, Allergist Immunologist), Nurse Practitioners, Registered Nurse (RN), Licensed Vocational Nurse (LVN), and Licensed Practical Nurse (LPN).

The course is available at www.anthem.com/asthma.equity (on demand) and is accessible from any mobile device, laptop, or desktop computer. Users must have access to Internet Explorer (9 or later), Google Chrome (38 or later), Safari (5 or later), Mozilla Firefox (32 or later).

In addition a Toolkit, called “Caring for Diverse Populations,” was developed to give Providers’ and Facilities specific tools for breaking through cultural and language barriers in an effort to better communicate
with their patients. Sometimes the solution is as simple as finding
the right interpreter for an office visit. Other times, a greater awareness of cultural sensitivities can open the
door to the kind of interaction that makes treatment plans most effective: Has the individual been raised in a
culture that frowns upon direct eye contact or receiving medical treatment from a member of the opposite
sex? Is the individual self-conscious about his or her ability to read instructions?

This toolkit gives Providers and Facilities the information needed to answer those questions and continue
building trust. It will enhance Providers and Facilities’ ability to communicate with ease, talking to a wide
range of people about a variety of culturally sensitive topics. And it offers cultural and linguistic training to
office staff so that all aspects of an office visit can go smoothly.

We strongly encourage Providers and Facilities to access the complete toolkit:
http://bridginghealthcaregaps.com/

The toolkit contents are organized into the following sections:

Improving Communications with a Diverse Patient Base
- Encounter tips for Providers and their clinical staff
- A memory aid to assist with patient interviews
- Help in identifying literacy problems

Tools and Training for Your Office in Caring for a Diverse Patient Base
- Interview guide for hiring clinical staff who have an awareness of cultural competency issues
- Availability of Medical Consumerism training for health educators to share with patients

Resources to Communicate Across Language Barriers
- Tips for locating and working with interpreters
- Common signs and common sentences in many languages
- Language identification flashcards
- Language skill self-assessment tools

Premier on How Cultural Background Impacts Health Care Delivery
- Tips for talking with people across cultures about a variety of culturally sensitive topics
- Information about health care beliefs of different cultural backgrounds

Regulations and Standards for Cultural and Linguistic Services
- Identifies important legislation impacting cultural and linguistic services, including a summary of the
  “Culturally and Linguistically Appropriate Services” (“CLAS”) standards which serve as a guide on
  how to meet these requirements.

Resources for Cultural and Linguistic Services
- A bibliography of print and Internet resources for conducting an assessment of the cultural and
  linguistic needs of a practice’s patient population
- Staff and physician cultural and linguistic competency training resources
- Links to additional tools in multiple languages and/or written for limited English proficiency

The toolkit contains materials developed by and used with the permission of the Industry Collaboration
Effort (“ICE”) Cultural and Linguistics Workgroup, a volunteer, multi-disciplinary team of providers, health
plans, associations, state and federal agencies and accrediting bodies working collaboratively to improve
health care regulatory compliance through public education. More information on the ICE Workgroup may
be obtained on the ICE Workgroup website: http://www.iceforhealth.org/home.asp

Cultural competency training available on anthem.com:
Creating an LGBT-Friendly Practice: Bridging Multicultural Health Care Gaps: What you may not know about your Lesbian, Gay, Bisexual, or Transgender (“LGBT”) patients may be putting their health at risk. Studies have shown that many LGBT patients fear they will be treated differently in health care settings and that this fear of discrimination prevents them from seeking primary care. Anthem joins you in striving for the best clinical outcomes for everyone, including LGBT populations. That’s why Anthem has created an online experience that provides strategies, tools, and resources to Providers and Facilities interested in attracting or maintaining an LGBT patient panel. Hopefully, as a result of increasing LGBT-friendly practices, we will see an increase in primary care and prevention among LGBT patients. Like you, Anthem strives to meet the needs of our diverse membership and upholds access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities these types of experiences, we can help keep all our Covered Individuals healthy. In addition, this online experience reinforces our commitment to equality for our LGBT Covered Individuals as referenced in our Provider and Facility contractual non-discrimination provisions.

Visit the provider pages online at www.anthem.com/lgbt for free 24/7 access to the experience – either via your computer, tablet or smartphone. You will gain an increased understanding of how to create an LGBT-friendly practice, which may improve the health of your patients. Approved for 1 AAFP Prescribed credit, which is equivalent to AMA PRA Category 1 Credit™.

Member Health and Wellness Programs

Anthem seeks to improve the lives of the Covered Individuals we serve. Anthem provides a unique blend of health and wellness programs to help Covered Individuals reach their total well-being goals. A quick overview of the programs and services Anthem offers is available by going to the Anthem.com. Select Menu, and then under the Support heading select the Providers link. Select the Health and Wellness link in the center of the page (Note: Navigation to this link is directly from this Provider page, do not select a state from the drop down list and enter).

Centers of Medical Excellence (CME) Transplant Network

Anthem currently offers access to Centers of Medical Excellence (“CME”) programs in solid organ and blood/marrow transplants, bariatric surgery, cardiac care, complex and rare cancers, maternity, spine surgery, and knee/hip replacement surgery. As much of the demand for CME programs has come from National Accounts, most of our programs are developed in partnership with the Blue Cross and Blue Shield Association (“BCBSA”) and other Blue plans to ensure adequate geographic coverage. The BCBSA refers to its designated CME hospitals as Blue Distinction Centers for Specialty Care™ (“BDC”). Using objective information and input from the medical community, the BCBSA has designated hospitals as Blue Distinction Centers that are proven to outperform their peers in the areas that matter to you – quality, safety and, in the case of Blue Distinction Centers+, efficiency.

For transplants, Covered Individuals also have access to the Anthem Centers of Medical Excellence Transplant Network. The CME designation is awarded to qualified programs by a panel of national experts currently practicing in the fields of solid organ or marrow transplantation representing transplant centers across the country. Each Center must meet Anthem’s CME participation requirements and is selected through a rigorous evaluation of clinical data that provides insight into the Facility’s structures, processes, and outcomes of care. Current designations include the following transplants: autologous/allogeneic bone marrow/stem cell, heart, lung, combination heart/lung, liver, kidney, simultaneous kidney/pancreas and pancreas.

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the facility delivers specialty care. More information on our programs can be accessed at anthem.com. Select Menu, and then under the Support heading, select the Providers link. Choose your state from the drop down list and enter. Select the Health & Wellness tab at the top of the page, and select Centers of Medical Excellence.
Transplant

- Blue Distinction Centers for Transplant™ (BDCT) program launched in 2006.
- More than 122,276 people in the United States were registered for organ donations from one of the nation's more than 800 transplant programs in 2015.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each facility meets stringent clinical criteria, established in collaboration with expert physicians' and medical organizations' recommendations**, including the Center for International Blood and Marrow Transplant Research ("CIBMTR"), the Scientific Registry of Transplant Recipients ("SRTR") and the Foundation for the Accreditation of Cellular Therapy ("FACT"), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction
- The AnthemCME Transplant Network is a wrap around network to the BDCT program and offers Covered Individuals access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, Covered Individuals have access to 300 transplant specific programs for heart, lung, combined heart lung, liver, pancreas, combined kidney pancreas and bone marrow/stem cell transplant.

Cardiac Care

- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, the number of adults with a diagnosis of heart disease is 27.6 million, and the percent of adults with diagnosed heart disease is 11.5%. Heart Disease is the #1 Cause of death in the United States.
- Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.
- Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery

- According to the National Center for Health Statistics report released in November 2015: Prevalence of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBSS), and the American College of Surgeons (ACS), and is subject to periodic re-evaluation as criteria continue to evolve.
- The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program ("MBSAQIP") accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center ("ASC").
Complex and Rare Cancers

- Blue Distinction Centers for Complex and Rare Cancers® launched in 2008.
- The Blue Distinction Centers for Complex and Rare Cancers program offers access to designated facilities for the treatment of 13 complex and rare cancers including esophageal cancer, pancreatic cancer, liver cancer, rectal cancer, gastric cancer, bone tumors, soft tissue sarcomas, brain tumors – primary, non-metastatic malignancies, bladder cancer, thyroid cancer – medullary or anaplastic, ocular melanoma, and head and neck cancers.
- Complex and Rare Cancers comprise approximately 15 percent of new cancer cases each year. The Blue Distinction Centers for Complex and Rare Cancers program evaluates facilities on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for complex and rare cancers. The Blue Cross and Blue Shield Association recognizes that the majority of patients’ multidisciplinary treatment may be best accomplished by integrating the expertise available in a Blue Distinction Center with locally available treatment resources, especially for outpatient chemotherapy and radiotherapy, based on individual circumstances and patient preference. Optimal support of a patient’s comprehensive cancer care needs may be achieved by coordination of care between the patient and their family, local physicians, the Blue Distinction Center and their local Blue Cross and Blue Shield Plan.
- The Blue Distinction Centers for Complex and Rare Cancers program was developed in collaboration with the National Comprehensive Cancer Network (“NCCN”), with input from a panel of nationally recognized clinical experts and utilizing published evidence, where available.

Spine Surgery

- Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.
- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, we have designated hospitals in the majority of states across the U.S..

Knee and Hip Replacement

- Blue Distinction Centers for Knee and Hip Replacement™ launched in November 2009.
- Blue Distinction Centers and Blue Distinction Centers+ for Knee and Hip Replacement provide comprehensive inpatient knee and hip replacement services, including total knee replacement and total hip replacement surgeries.

Maternity Care

- Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care launched in 2016 and offers access to healthcare facilities with demonstrated expertise and a commitment to quality care during the delivery episode of care, which includes both vaginal and cesarean section delivery.
- The Maternity Care designation uses publicly available data from Hospital Compare data which includes the Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital Consumer Assessment of Healthcare Providers and Systems (“HCAHPS”).
Covered Individual Grievance and Appeal Process

To help ensure that Covered Individuals’ rights are protected, all Anthem Covered Individuals are entitled to a complaints and appeals process.

Procedures for registering complaints and appeals are outlined in the Covered Individual’s certificate of coverage. Refer to the Anthem Medicare Advantage HMO and PPO Provider Guidebook (formerly known as the Medicare Advantage HMO and PPO Provider Manual) for a description of Medicare Advantage procedures for Covered Individual grievances and appeals.

Complaints

Complaints include any expression of dissatisfaction regarding Anthem's services, products, Providers or Facilities and employees.

• Anthem’s Covered Individual services department logs oral and written complaints into a tracking system, may research the issue, if appropriate, and responds to the Covered Individual.

• Anthem monitors Covered Individual services complaint response time to promote timely resolutions of Covered Individual complaints.

Appeals

Appeals refer to formal requests by the Covered Individual (or his/her authorized representative) to change a decision previously made by Anthem. Therefore, if a complaint is not resolved to the Covered Individual’s satisfaction, he/she may contact Anthem Covered Individual services to initiate a formal appeal or the address or phone number contained on the notice of an adverse decision by Anthem. Covered Individuals may also file a formal appeal without first filing a complaint. An appeal specialist/appeal grievance unit (for Medicare Advantage Covered Individuals) then reviews all available documentation, with assistance from medical and/or network management if necessary.

• Anthem then determines whether to reverse or uphold the original decision.

• Following the determination, Anthem sends the Covered Individual a written notification of the appeal determination and the appeal is closed.

• A Covered Individual is advised of any additional appeal rights available to him/her.

• An external appeal is also available to the Covered Individual in some circumstances when the internal appeals process is exhausted without resolution to the Covered Individual’s satisfaction.

Quality of Care Issues

Anthem can identify quality of care issues through the appeals process and/or telephone contact with a Covered Individual.

When Anthem identifies an issue, we contact the Covered Individual with a letter confirming the review, research each issue and, if necessary, take action to correct the problem. All issues are trended and used as part of the provider evaluation at the time of recredentialing.
Provider and Facility Complaint and Appeals Process

Anthem encourages Providers and Facilities to seek resolution of issues by using the provider complaint and appeal process outlined in the Guide to Provider Complaints and Appeals available under Answers@Anthem on our public provider website. The process is designed to provide appropriate and timely review when Providers and Facilities disagree with a decision made by Anthem. The process also meets requirements of state laws and accreditation agencies.

Timeframes for Submitting Complaints and Appeals

Providers and Facilities have one hundred eighty (180) calendar days to file an appeal from the date they receive notice of Anthem's initial decision.

All standard post-service clinical appeals will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than sixty (60) calendar days from the receipt of the grievance request by Anthem.

Providers and Facilities filing pre-service appeals will be handled as filing on behalf of the member. Anthem will follow the timeframes established in the member's certificate of coverage when responding to these types of appeals.

Unless the Covered Individual, on his or her own behalf, or another Provider or Facility has already filed an expedited appeal on the service at issue in the appeal, a Provider or Facility that requests an expedited appeal will be deemed to be the member's designated representative for the limited purpose of filing the expedited appeal. As a result, the expedited appeal will be handled pursuant to the Anthem Covered Individual Appeal Procedures exclusively.

How Special Complaints and Appeals are Handled

Certain types of complaints or appeals are handled by specific Anthem departments and may follow different policies and procedures. The following is a brief summary of some of the special complaint and appeal procedures.

Covered Individual Complaints and Appeals

Anthem Covered Individuals may designate a representative to exercise their complaint and appeal rights. When a Provider and Facility is acting on behalf of a Covered Individual as the designated representative, the complaint or appeal may be submitted to the Provider Inquiry department. These types of issues are reviewed according to Anthem's Covered Individual Complaint and Appeal Procedures, for each applicable state.

Network Participation Appeals

Providers or Facilities who are terminated or rejected from Anthem’s Network(s) for failure to satisfy Anthem’s participation requirements, may appeal Anthem's decision. Anthem will send a letter of explanation that outlines how to initiate an appeal. In general, the Provider or Facility has thirty (30) days from receipt of this notice to request that Anthem reconsider its decision. The appeal process will vary depending upon the type of provider (physician, Facility, ancillary), the Anthem Network in question, the state in which the Provider or Facility is located, and the reason for the termination. For more information, please see the credentialing section of this manual.

Most Anthem plans follow this process. Certain plans including the Federal Employee Service Benefit PPO plans and self-funded plans may have different processes.

For More Information

Questions concerning the complaint and appeals process can be directed to the Provider Inquiry Department at (800) 282-1016 or your provider relations/network management representative.
Member Quality of Care ("QOC") Investigations

Overview

The Grievances and Appeals department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service ("QOC"/"QOS") concerns or sentinel events involving Anthem Covered Individuals. This includes cases reviewed as the result of a grievance submitted by a Covered Individual and potential quality issues (PQI) reviewed as the result of a referral received from an Anthem clinical associate. All Anthem associates who may encounter clinical care/service concerns or sentinel events are informed of these policies.

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and/or Facility are requested. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a Covered Individual grievance, the Covered Individual is sent a resolution letter within thirty (30) calendar days of Anthem's receipt of the grievance. The Covered Individual is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

Significant quality of care issues may be elevated to the regional Peer Review Committee for Second Level Peer Review. This may result in a subsequent referral to the appropriate Credentials Committee.

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective action planning.

Corrective Action Plans ("CAP")

When corrective action is required, the Medical Director or the applicable local Peer Review Committee will determine appropriate follow-up interventions which can include one or more of the following: a CAP from the Provider and/or Facility, CME, chart reviews, on-site audits, tracking and trending, Provider and/or Facility counseling, and/or referral to the appropriate committee.

Reporting

G&A leadership reports grievance and PQI rates, categories, and trends; to the appropriate Quality Improvement Committee on a bi-annual basis or more often as appropriate. Quality improvement or educational opportunities are reported, and corrective measures implemented, as applicable. Results of corrective actions are reported to the Committee. The Quality Council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

Severity Levels for Quality Assurance

<table>
<thead>
<tr>
<th>Level</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-0</td>
<td>0</td>
<td>No quality of care issue found to exist.</td>
</tr>
<tr>
<td>C-1</td>
<td>0</td>
<td>Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.</td>
</tr>
<tr>
<td>C-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue that adversely affected the care rendered.</td>
</tr>
<tr>
<td>C-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.</td>
</tr>
</tbody>
</table>
C-4 10  Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.

C-5 15  Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.

C-6 25  Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.

<table>
<thead>
<tr>
<th>Level</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-0</td>
<td>0</td>
<td>No quality of service or administrative issue found to exist.</td>
</tr>
<tr>
<td>S-1</td>
<td>0</td>
<td>Member grievances regarding practitioner’s office: physical accessibility, physical appearance, and adequacy of the waiting-room and examining-room space.</td>
</tr>
<tr>
<td>S-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue with no adverse medical effect on member.</td>
</tr>
<tr>
<td>S-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance despite two requests per internal guidelines.</td>
</tr>
<tr>
<td>S-4</td>
<td>5</td>
<td>Confirmed discrimination, confirmed HIPAA violation, confirmed confidentiality and/or privacy issue.</td>
</tr>
</tbody>
</table>

Trend Threshold for Analysis

Quality of Care and Service Trend Parameters

The following accumulation of QOC and QOS cases with severity levels and points, or any combination of cases totaling 20 points or more during a rolling 12 months will be subject to trend analysis:

- 8 cases with a leveling of C-0 and S-0
- 4 cases with a leveling of C-1
- 4 cases with a leveling of C-2 and S-2
- 4 cases with a leveling of C-3 and S-3
- 2 cases with a leveling of C-4
- 2 cases with a leveling of C-5
- 1 case with a leveling of C-6 (automatic referral to the applicable Peer Review Committee)
- 3 cases with a leveling of S-1 (for a specific office location in a 6 month period); refer for site visit
- 4 cases with a leveling of S-4 (automatic referral to the applicable Provider Review Committee)

A rolling 12 month cumulative level report is generated monthly and reviewed by a G&A clinical associate for trend identification. (Four similar complaints constitute a trend).

An analysis is completed by the G&A clinical associate and forwarded to the Medical Director to determine if there is a pattern among the cases. For example, a provider who repeatedly fails to return phone calls to postoperative patients resulting in the potential for or an actual adverse outcome. The Medical Director will determine if further action is warranted, such as the need for a corrective action plan, or referral to the appropriate committee for further review and action, as appropriate.

Corrective action plans received for QOC issues are reviewed by the Medical Director and may be forwarded to the applicable local Peer Review Committee for further review and follow up, as appropriate.

A provider who does not submit the corrective action plan by the deadline or who does not comply with the terms of the corrective action plan will be referred to the Credentialing Committee for further action, which may include termination from the network.
Product Summary

Anthem Blue Cross and Blue Shield Products

Please refer to Plans and Benefits on www.Anthem.com or its successor for additional information.

Federal Employee Health Benefit Program Plans

Please refer to the Benefits and Services on the Federal Employee Health Benefit Program (FEHBP) Web Site at www.fepblue.org for additional information.

Other Products

Please refer to Plans and Benefits on www.Anthem.com or its successor for additional information.

Medicare Advantage

Medicare Advantage Provider Website

Please refer to the Medicare Eligible website online for additional information at www.anthem.com/medicareprovider.

Medicare Advantage Provider Manuals are available on the Medicare Eligible website referenced above.

Medicare Advantage HMO and PPO Provider Guidebook

Federal Employee Health Benefit Plan

FEHBP Program Requirements

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employee Health Benefit Program (“FEHBP”). The Anthem FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as “Federal Employee Program®” or “FEP®,” – the health insurance Plan for federal employees. Provider and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management. Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulation, and other requirements of the FEHBP shall control.

When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employee Health Benefit Program

All Claims under the FEHBP must be submitted to Plan for payment within one hundred eighty (180) calendar days from the date of discharge or from the date of the primary payer’s explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Anthem or Covered Individual all information necessary for Plan to determine its liability, including, without limitation, accurate and complete Claims for Covered Services,
utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payor, the one hundred eighty (180) calendar day period will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after this one hundred eighty (180) calendar day period. Except where the Covered Individual did not provide Plan identification, Provider and Facility shall not bill, collect, or attempt to collect from Covered Individual for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

Erroneous or Duplicate Claim Payments under the FEHBP

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made within five (5) years from the end of the calendar year in which the erroneous or duplicate Claim was submitted. In lieu of a refund, Plan may offset future Claim payments.

Coordination of Benefits for FEHBP

In certain circumstances when the FEHBP is the secondary payer and there is no adverse effect on the Covered Individual, the FEHBP pays the local Plan allowable minus the Primary payment. The combined payments from both the primary payer and FEHBP as the secondary payer, might not equal the entire amount billed by the Provider or Facility for covered services.

FEHBP Waiver Requirements

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

FEHBP Member Reconsiderations and Appeals

There are specific procedures for reviewing disputed Claims under the Federal Employees Health Benefits Program. The process has two steps, starting with a review by the local Plan (reconsideration), which may lead to a review by the Office of Personnel Management (OPM).

The review procedures are designed to provide Covered Individuals with a way to resolve Claim disputes as an alternative to legal actions.

The review procedures are intended to serve both contract holders and Covered Individuals. The local Plan and OPM do not accept requests for review from Providers or Facilities, except on behalf of, and with the written consent of, the contract holder or Covered Individual.

Providers and Facilities are required to demonstrate that the contract holder or Covered Individual has assigned all rights to the Provider or Facility for that particular Claim or Claims.

When a Claim or request for Health Services, drugs or supplies – including a request for precertification or prior approval – is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the Covered Individual, contract holder or their authorized representative. The request for review must be received within six months of the date of the Plan’s final decision. If the request for review is on a specific Claim(s), the Covered Individual must be financially liable in order to be eligible for the disputed Claims process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 (thirty) calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 (sixty) calendar days, the Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. If the
Plan does not completely satisfy the Covered Individual’s request, the Plan will advise the Covered Individual of his/her right to appeal to OPM.

Providers or Facilities may not submit appeals to the OPM. Only the Covered Individual or contract holder may do so, as outlined in the Blue Cross and Blue Shield Service Benefit Plan brochure.

FEHBP Formal Provider and Facility Appeals

Providers and Facilities, are entitled to pursue disputes of their pre-service request (this includes pre-certification or prior approval) or their post-service claim (represents a request for reimbursement of benefits for medical services that have already been performed), by following a formal dispute resolution process.

A formal Provider or Facility appeal is a written request from the rendering Provider or Facility, to his/her local Plan, to have the local Plan re-evaluate its contractual benefit determination of their post-service Claim; or to reconsider an adverse benefit determination of a pre-service request. The request must be from a Provider or Facility and must be submitted in writing within 180 days of the denial or benefit limitation. In most cases, this will be the date appearing on the Explanation of Benefits/Remittance sent by the Plan. For pre-service request denials, the date will be the date appearing on the Plan’s notification letter.

The request for review may involve the Provider or Facility’s disagreement with the local Plan’s decision about any of the clinical issues listed below where the Providers or Facilities are not held harmless. Local Plans should note that this list is not all-inclusive.

1. not medically necessary (NMN);
2. experimental/investigational (E/I);
3. denial of benefits, in total or in part, based on clinical rationale (NMN or E/I);
4. precertification of hospital admissions; and,
5. prior approval (for a service requiring prior approval under FEHBP).

Not all benefit decisions made by local Plans are subject to the formal Provider and Facility appeal process. The formal Provider and Facility appeal process does not apply to any non-clinical case.

When a Claim or request for services, drugs or supplies -- including a request for precertification or prior approval -- is denied, whether in full or partially, the local Plan that denied the Claim reviews the benefit determination upon receiving a written request for review. This request must come from the rendering/requesting Provider or Facility. The request for review must be received within six months of the date of the local Plan’s final decision. If the request for review is on a specific Claim(s), the Provider or Facility must be financially liable in order to be eligible for the formal Provider and Facility appeal process.

The local Plans must respond to the request in writing, affirming the benefits denial, paying the Claim, or requesting the additional information necessary to make a benefit determination, within 30 calendar days of receiving the request for review. If not previously requested, the local Plan is required to obtain all necessary medical information, such as operative reports, medical records and nurses’ notes, related to the Claim. If the additional information is not received within 60 calendar days, the local Plan will make its decision based on the information available. Appropriate medical review will also be done at this time. Even if the local Plan does not completely satisfy the Provider or Facility’s request, the formal Provider and Facility appeal process is complete; no additional appeal rights are available.

BlueCard Program Overview

BlueCard is a national program that enables Covered Individuals of one Blue Plan to obtain healthcare service benefits while traveling or living in another Blue Plan’s service area. The program links participating healthcare Providers and Facilities with the independent Blue Plans across the country and in more than 200 countries and territories worldwide through a single electronic network for Claims processing and reimbursement. The program allows Providers and Facilities to submit Claims for Covered Individuals from other Blue Plans, domestic and international, to Anthem. Anthem is the sole contact for Claims payment, adjustments and issue resolution.

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at anthem.com.
Health Insurance Marketplace (exchanges)

Health Insurance Marketplace

The Affordable Care Act (ACA) calls for the development of health plans offered on Health Insurance Marketplaces (commonly referred to as exchanges), as well as health plans not purchased on public exchanges. To support this initiative, Anthem developed and/or designated specific networks to serve these ACA compliant health plans and reflect the needs of our membership. Providers and Facilities can easily identify these ACA compliant plans by the network name noted on the Covered Individual ID card.

Critical updates about the products offered on the exchange and the networks supporting these ACA compliant Plans can be found on the Health Insurance Exchange information dedicated web page from our Provider Home page. Go to anthem.com, select Menu, and under the Support heading select the Providers link. Choose your state from the drop down list and enter. In addition to posting information to our website, articles are published in our provider newsletter, Network Update, and sent via our email service, Network eUPDATE, to communicate information about exchanges.

Important reminders

Providers and Facilities are able to confirm their participation status by using the Find a Doctor tool. You are able to search by a specific provider name, or view a list of local in-network Providers and Facilities using search features such as provider specialty, zip code, and plan type.

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services at (800)282-1016.

Accessing the Online Provider Directory:

- Go to anthem.com
- Select Menu, and then under the Support heading select the Providers link. Choose your state from the drop down list and enter.
- From the Provider Home tab, select the blue box titled “Find a Doctor” to search our online Provider Directory

If you are referring a Covered Individual to another provider or facility, please verify that the provider is participating in the Covered Individual’s specific network.

It is critical that your patients receive accurate and current data related to provider availability. As outlined in your Agreement, please notify Anthem within 10 business days of all changes listed below. Please note tax ID changes must be accompanied by a W-9 to be valid.

- Telephone number for Covered Individuals to schedule appointments at your practice location
- Practice/Facility location address
- Practice/Facility Office Hours
- Provider/Facility name
- Practice name
- Practice affiliation changes (i.e. provider joined another group)
- Providers leaving, retiring or joining your practice
- Billing address
- Tax ID number
- Specialties
- Hospital privileges
- Accepting new patients
- Handicapped Accessibility
- Languages offered

Please send us this information timely, preferably within 10 business days, by submitting an Online Provider Maintenance Form:
Audit

Anthem Audit Policy

This Anthem Audit Policy applies to Providers and Facilities. If there is conflict between this Policy and the terms of the applicable Provider or Facility Agreement, the terms of the Agreement will prevail. If there is a conflict in provisions between this Policy and applicable state law that is not addressed in the Provider or Facility Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider or Facility Agreement between Anthem and Provider or Facility.

Coverage is subject to the terms, conditions, and limitations of a Covered Individual’s Health Benefit Plan and in accordance with this Policy.

There may be times when Anthem conducts claim reviews or audits either on a prepayment or post payment basis. Claim reviews and audits are conducted in order to confirm that healthcare services or supplies were delivered in compliance with the Covered Individual’s plan of treatment or to confirm that charges were accurately reported in compliance with Anthem’s policies and procedures as well as general industry standard guidelines and regulations.

In order to conduct such reviews and audits, Anthem or its designee may request documentation, most commonly in the form of patient medical records. Anthem may accept additional documentation from Provider or Facility that typically might not be included in medical records such as other documents substantiating the treatment or health service or delivery of supplies, Provider’s or Facility’s established internal policies, professional licensure standards that reference standards of care, or business practices justifying the healthcare service or supply. The Provider or Facility must review, approve and document all such internal policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies and such policies shall be made available for review by the auditor.

This policy documents Anthem’s guidelines for claims requiring additional documentation and the Provider’s or Facility’s compliance for the provision of requested documentation.

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Anthem and Provider or Facility that describes the duties and obligations of Anthem and the Provider or Facility, and which contains the terms and conditions upon which Anthem will reimburse Provider or Facility for Health Services rendered by Provider or Facility to Covered Individual(s).

- Appeal means Anthem’s or its designee’s review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.

- Appeal Response means Anthem’s or its designee’s written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.

- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

- Audit Report and Notice of Overpayment (“Audit Report”) means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit that constitute the basis for Anthem’s or its designee’s belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
• Business Associate or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.

• Provider or Facility means an entity with which Anthem has a written Agreement.

• Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines certain Anthem Policies.

• Recoupment means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.

• Supporting Documentation means the written material contained in a Covered Individual's medical records or other Provider or Facility documentation that supports the Provider's or Facility's claim or position that no overpayment has been made by Anthem.

Policy
Upon request from Anthem or its designee, facilities are required to submit additional documentation for claims identified for pre-payment review or post payment audit. Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits for Covered Individuals after validity review of the Covered Individual’s medical records
6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Covered Individuals
7. Claims requesting an extension of benefits
8. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
9. Claims for services that require an invoice
10. Claims for services that require an itemized bill
11. Claims for beneficiaries where other health insurance (OHI) is indicated with the claim submission
12. Claims requiring documentation of the receipt of an informed consent form
13. Claims requiring a certificate of Medical Necessity
14. Appealed claims where supporting documentation may be necessary for determination of payment
15. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
16. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

Anthem or its designee will use the following guidelines for records requests and the adjudication of claims identified for prepayment review or post payment audit:

1. Upon confirmation of Provider’s or Facility’s address, an original letter of request for supporting documentation will be sent.
2. When a response is not received within 30 days of the date of the initial request, a second request letter will be sent.
3. When a response is not received within 15 days of the second request, a final request letter will be sent.
4. When a response is not received within 15 days of the date of the final request (60 days total):
   a. Anthem or its designee will initiate claim denial for claims identified as pre-payment review claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment denials.
   or
b. Anthem or its designee will initiate claim retractions for claims identified as post payment audit claims as Provider or Facility failed to submit the required documentation. The Covered Individual shall be held harmless for such payment retractions.

Anthem or its designee will not be liable for interest or penalties when payment is denied or recouped when Provider or Facility fails to submit required or requested documentation for claims identified for prepayment or post payment audit.

[This policy will not supersede any individual Provider or Facility contract provisions or state or federal guidelines.]

Procedure:

1. **Review of Documents.** Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem or its designee within the time frame outlined above.

2. **Scheduling of Audit.** After review of the documents submitted, if Anthem or its designee determine an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

3. **Rescheduling of Audit.** Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider’s or Facility’s new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider’s or Facility’s rescheduling.

4. **Under-billed and Late-billed Claims.** During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.

5. **Scheduling Conflicts.** Should the Provider or Facility fail to work with Anthem or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

6. **On-Site and Desk Audits.** Anthem or its designee may conduct Audits from its offices or on-site at the Provider’s or Facility’s location. If Anthem or its designee conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for Anthem’s or its designee’s on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Covered Individual authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider’s or Facility’s patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. **Completion of Audit.** Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is
completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.

8. **Provider or Facility Appeal.** See Audit Appeal Policy.

9. **No Appeal.** If the Provider or Facility does not formally Appeal the findings in the final Audit Report and submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

**Documents Reviewed During an Audit:**

The following is a description of the documents that may be reviewed by the Anthem or its designee along with a short explanation of the importance of each of the documents in the Audit process. It is important to note that Providers and Facilities must comply with applicable state and federal record keeping requirements.

A. **Confirm that Health Services were delivered by the Provider or Facility in compliance with the plan of treatment.**

Auditors will verify that Provider’s or Facility’s plan of treatment reflected the Health Services delivered by the Provider or Facility. The services are generally documented in the Covered Individual’s health or medical records. In situations where such documentation is not found in the Covered Individual’s medical record, the Provider or Facility may present other documents substantiating the treatment or Health Service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the Health Service or supply. The Provider or Facility Must review, approve and document all such policies and procedures as required by The Joint Commission (“TJC”) or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

B. **Confirm that charges were accurately reported on the Claim in compliance with Anthem’s Policies as well as general industry standard guidelines and regulations.**

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Covered Individual’s health record documents. The health record records the clinical data on diagnoses, treatments, and outcomes. A health record generally records pertinent information related to care and in some cases, the health record may lack the documented support for each charge on the Covered Individual’s Claim. Other appropriate documentation for Health Services provided to the Covered Individual may exist within the Provider’s or Facility’s ancillary departments in the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Covered Individual’s Claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.
Audit Appeal Policy

Purpose:

To establish a timeline for issuing Audits and responding to Provider or Facility Appeals of such Audits.

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.

2. A Provider’s or Facility’s written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem’s or its designee’s sole discretion, for up to thirty (30) calendar days from the date the Appeal would have otherwise been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider's or Facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.

3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem’s or its designee’s response shall address each matter contained in the Provider's or Facility’s Appeal. If appropriate, Anthem’s or its designee’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem’s or its designee’s response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider’s or Facility’s Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem’s or its designee’s response, and a confirming recoupment notification will be sent to the Provider or Facility.

5. Upon receipt of a timely Provider or Facility response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem’s or its designee’s final Appeal Response shall address each matter contained in the Provider’s or Facility’s response. If appropriate, Anthem’s or its designee’s final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem’s or its designee’s final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.

6. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem’s or its designee’s final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.

7. If Provider or Facility still disagrees with Anthem’s or its designee’s position after receipt of the final Appeal Response, Provider or Facility may invoke the dispute resolution mechanisms under the Agreement.
Fraud, Waste and Abuse Detection

Anthem recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse , and is committed to protecting and preserving the integrity and availability of health care resources for our Covered Individuals, clients, and business partners. Anthem accordingly maintains a program to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans. All Claims submissions are subject to review and/or audit for possible fraud, waste and abuse. Prevention and detection of fraud, waste and abuse is in accordance with applicable State and Federal law.

Pre-Payment Review

One method Anthem utilizes to detect fraud, waste and abuse is through pre-payment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Anthem’s attention for or behavior that might be identified as unusual, or for coding or billing or Claims activity which indicates the Provider or Facility is an outlier with respect to his/her/its peers. For example, Anthem uses computer algorithm software tools that are designed to identify Providers or Facilities whose billing practices, including billing or coding practices, indicates conduct that is unusual or outside the norm of the Provider’s or Facility’s peers.

Once a Claim, or a Provider or Facility, is identified as an outlier, further investigation is conducted by the SIU to determine the reason(s) for the outlier status or any appropriate explanation for an unusual Claim, coding or billing practice. If the investigation results in a determination that the Provider’s or Facility’s actions may involve fraud, waste or abuse, the Provider or Facility is notified and given an opportunity to respond.

If, despite the Provider’s or Facility’s response, Anthem continues to believe the Provider’s or Facility’s actions involve fraud, waste or abuse, or some other inappropriate activity, the Provider or Facility will then be notified the Provider or Facility is being placed on pre-payment review. This means that the Provider or Facility will be required to submit medical records with each Claim so Anthem can review the services being billed. Failure to submit medical records to Anthem in accordance with this requirement will result in a rejection of the Claim under review. The Provider’s or Facilities will be given the opportunity to request a discussion of his/her/its pre-payment review status.

Under the pre-payment review program, Anthem may review coding and other billing issues. In addition, we may use one or more clinical utilization management guidelines in the review of Claims submitted by the Provider or Facility, even if those guidelines are not used for all Providers or Facilities delivering services to Plan’s Covered Individuals.

The Provider or Facility will remain subject to the pre-payment review process until Anthem is satisfied that any inappropriate activity has been corrected. If the inappropriate activity is not corrected, the Provider or Facility could face corrective measures, up to and including termination from our Network.

Finally, Providers and Facilities are prohibited from billing Covered Individuals for services we have determined are not payable as a result of the pre-payment review process, whether due to fraud, waste or abuse, any other coding or billing issue or for failure to submit medical records as set forth above. Providers or Facilities whose Claims are determined to be not payable may make appropriate corrections and resubmit such Claims in accordance with the terms of the applicable Provider or Facility agreement and state law. Providers or Facilities also may appeal such determination in accordance with applicable grievance and appeal procedures.
Links

BlueCard

Centers of Medical Excellence/Blue Distinction
http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/noapplication/f2/s3/t0/pw_ad094863.htm&state=oh&rootLevel=1&label=Centers of Medical Excellence

Coordination of Benefits Questionnaire
http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_ad095423.pdf?refer=ahpprovider&state=in

Federal Employee Program
http://www.fepblue.org/

Medicare Advantage
http://www.anthem.com/medicareprovider

Network eUpdate (formerly Rapid Update) Email Sign-up Form
http://www.anthem.com/forms/central/network_rapid_updates.html

Provider Adjustment Form
http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/oh/f4/s0/t0/pw_ad080344.htm&rootLevel=3&state=oh&label=Provider%20Adjustment%20Forms&state=oh&rootLevel=3

Provider Maintenance Form

Quality

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