ANTHEM
BLUE CROSS AND BLUE SHIELD
PROVIDER MANUAL
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**Purpose and Introduction**

Anthem Blue Cross and Blue Shield in Virginia is committed to working with Providers and Covered Individuals to provide a high level of satisfaction in delivering quality care. The Anthem Professional Provider Manual is an integral part of this commitment, providing information on key contractual terms, products, eligibility, Claims submission, coverage guidelines and a directory of resources.

In summary, this manual communicates administrative and billing requirements. As Anthem makes changes to these requirements, this Manual will serve as a vehicle for communicating these changes.

**Future Updates**

Anthem is committed to providing contracted Providers with an accurate and up-to-date Professional Provider 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 distribute updated documentation in the next manual update. In those instances when Anthem determines that information in this manual differs from that in the Agreement, the Agreement will take precedence over the Manual.
Fair Business Practice Act (FBPA)

Fair Business Practice Act (FBPA)

** Please note this section does not apply to Medicaid or Medicare related business.

A. As used in this section:

"Carrier," "enrollee" and "provider" shall have the meanings set forth in Section 38.2-3407.10; however, a "carrier" shall also include any person required to be licensed under this title which offers or operates a managed care health insurance plan subject to Chapter 58 (Section 38.2-5800 et seq.) of this title or which provides or arranges for the provision of health care services, health plans, networks or provider panels which are subject to regulation as the business of insurance under this title.

"Claim" means any bill, claim, or proof of loss made by or on behalf of an enrollee or a provider to a carrier (or its intermediary, administrator or representative) with which the provider has a provider contract for payment for health care services under any health plan; however, a "claim" shall not include a request for payment of a capitation or a withhold.

"Clean claim" means a claim (i) that has no material defect or impropriety (including any lack of any reasonably required substantiation documentation) which substantially prevents timely payment from being made on the claim or (ii) with respect to which a carrier has failed timely to notify the person submitting the claim of any such defect or impropriety in accordance with this section.

"Health care services" means items or services furnished to any individual for the purpose of preventing, alleviating, curing, or healing human illness, injury or physical disability.

"Health plan" means any individual or group health care plan, subscription contract, evidence of coverage, certificate, health services plan, medical or hospital services plan, accident and sickness insurance policy or certificate, managed care health insurance plan, or other similar certificate, policy, contract or arrangement, and any endorsement or rider thereto, to cover all or a portion of the cost of persons receiving covered health care services, which is subject to state regulation and which is required to be offered, arranged or issued in the Commonwealth by a carrier licensed under this title. Health plan does not mean (i) coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. Section 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. Section 1396 et seq. or Title XX of the Social Security Act, 42 U.S.C. Section 1397 et seq. (Medicaid), 5 U.S.C. Section 8901 et seq. (federal employees), or 10 U.S.C. Section 1071 et seq. (CHAMPUS); or (ii) accident only, credit or disability insurance, long-term care insurance, CHAMPUS supplement, Medicare supplement, or workers' compensation coverages.

"Provider contract" means any contract between a provider and a carrier (or a carrier's network, provider panel, intermediary or representative) relating to the provision of health care services.

"Retroactive denial of a previously paid claim" or "retroactive denial of payment" means any attempt by a carrier retroactively to collect payments already made to a provider with respect to a claim by reducing other payments currently owed to the provider, by withholding or setting off against future payments, or in any other manner reducing or affecting the future claim payments to the provider.

B. Subject to subsection H, every provider contract entered into by a carrier shall contain specific provisions which shall require the carrier to adhere to and comply with the following minimum fair business standards in the processing and payment of claims for health care services:

1. A carrier shall pay any claim within forty days of receipt of the claim except where the obligation of the carrier to pay a claim is not reasonably clear due to the existence of a reasonable basis supported by specific information available for review by the person submitting the claim that:

   a. The claim is determined by the carrier not to be a clean claim due to a good faith determination or dispute regarding (i) the manner in which the claim form was completed or submitted, (ii) the eligibility of a person for coverage, (iii) the responsibility of another carrier for all or part of the claim, (iv) the amount of the claim or the amount currently due under the claim, (v) the benefits covered, or (vi) the manner in which services were accessed or provided; or

   b. The claim was submitted fraudulently.
Each carrier shall maintain a written or electronic record of the date of receipt of a claim. The person submitting the claim shall be entitled to inspect such record on request and to rely on that record or on any other admissible evidence as proof of the fact of receipt of the claim, including without limitation electronic or facsimile confirmation of receipt of a claim.

2. A carrier shall, within thirty days after receipt of a claim, request electronically or in writing from the person submitting the claim the information and documentation that the carrier reasonably believes will be required to process and pay the claim or to determine if the claim is a clean claim. Upon receipt of the additional information requested under this subsection necessary to make the original claim a clean claim, a carrier shall make the payment of the claim in compliance with this section. No carrier may refuse to pay a claim for health care services rendered pursuant to a provider contract which are covered benefits if the carrier fails timely to notify or attempt to notify the person submitting the claim of the matters identified above unless such failure was caused in material part by the person submitting the claims; however, nothing herein shall preclude such a carrier from imposing a retroactive denial of payment of such a claim if permitted by the provider contract unless such retroactive denial of payment of the claim would violate subdivision 6 of this subsection. Nothing in this subsection shall require a carrier to pay a claim which is not a clean claim.

3. Any interest owing or accruing on a claim under Section 38.2-3407.1 or 38.2-4306.1 of this title, under any provider contract or under any other applicable law, shall, if not sooner paid or required to be paid, be paid, without necessity of demand, at the time the claim is paid or within sixty days thereafter.

4. a. Every carrier shall establish and implement reasonable policies to permit any provider with which there is a provider contract (i) to confirm in advance during normal business hours by free telephone or electronic means if available whether the health care services to be provided are medically necessary and a covered benefit and (ii) to determine the carrier's requirements applicable to the provider (or to the type of health care services which the provider has contracted to deliver under the provider contract) for (a) pre-certification or authorization of coverage decisions, (b) retroactive reconsideration of a certification or authorization of coverage decision or retroactive denial of a previously paid claim, (c) provider-specific payment and reimbursement methodology, coding levels and methodology, down coding, and bundling of claims, and (d) other provider-specific, applicable claims processing and payment matters necessary to meet the terms and conditions of the provider contract, including determining whether a claim is a clean claim. If a carrier routinely, as a matter of policy, bundles or down codes claims submitted by a provider, the carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall either (i) disclose in its provider contracts or on its website the specific bundling and down coding policies that the carrier reasonably expects to be applied to the provider or provider's services on a routine basis as a matter of policy or (ii) disclose in each provider contract a telephone or facsimile number or e-mail address that a provider can use to request the specific bundling and down coding policies that the carrier reasonably expects to be applied to that provider or provider's services on a routine basis as a matter of policy. If such request is made by or on behalf of a provider, a carrier shall provide the requesting provider with such policies within 10 business days following the date the request is received.

b. Every carrier shall make available to such providers within ten business days of receipt of a request, copies of or reasonable electronic access to all such policies which are applicable to the particular provider or to particular health care services identified by the provider. In the event the provision of the entire policy would violate any applicable copyright law, the carrier may instead comply with this subsection by timely delivering to the provider a clear explanation of the policy as it applies to the provider and to any health care services identified by the provider.

5. Every carrier shall pay a claim if the carrier has previously authorized the health care service or has advised the provider or enrollee in advance of the provision of health care services that the health care service are medically necessary and a covered benefit, unless:

The documentation for the claim provided by the person submitting the claim clearly fails to support the claim as originally authorized; or

The carrier's refusal is because (i) another payor is responsible for the payment, (ii) the provider has already been paid for the health care services identified on the claim, (iii) the claim was submitted fraudulently or the authorization was based in whole or material part on erroneous information provided to the carrier by the provider, enrollee, or other person not related to the carrier, or (iv) the person receiving the health care
services was not eligible to receive them on the date of service and the carrier did not know, and with the exercise of reasonable care could not have known, of the person’s eligibility status.

6. No carrier may impose any retroactive denial of a previously paid claim unless the carrier has provided the reason for the retroactive denial and (i) the original claim was submitted fraudulently, (ii) the original claim payment was incorrect because the provider was already paid for the health care services identified on the claim or the health care services identified on the claim were not delivered by the provider, or (iii) the time which has elapsed since the date of the payment of the original challenged claim does not exceed the lesser of (a) twelve months or (b) the number of days within which the carrier requires under its provider contract that a claim be submitted by the provider following the date on which a health care service is provided. Effective July 1, 2000, a carrier shall notify a provider at least thirty days in advance of any retroactive denial of a claim.

7. Notwithstanding subdivision 6 of this subsection, with respect to provider contracts entered into, amended, extended, or renewed on or after July 1, 2004, no carrier shall impose any retroactive denial of payment or in any other way seek recovery or refund of a previously paid claim unless the carrier specifies in writing the specific claim or claims for which the retroactive denial is to be imposed or the recovery or refund is sought. The written communication shall also contain an explanation of why the claim is being retroactively adjusted.

8. No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision 4 of this subsection) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract.

9. No amendment to any provider contract or to any addenda, schedule, exhibit or policy thereto (or new addenda, schedule, exhibit, or policy) applicable to the provider (or to the range of health care services reasonably expected to be delivered by that type of provider) shall be effective as to the provider, unless the provider has been provided with the applicable portion of the proposed amendment (or of the proposed new addenda, schedule, exhibit, or policy) at least 60 calendar days before the effective date and the provider has failed to notify the carrier within 30 calendar days of receipt of the documentation of the provider’s intention to terminate the provider contract at the earliest date thereafter permitted under the provider contract.

10. In the event that the carrier’s provision of a policy required to be provided under subdivision 8 or 9 of this subsection would violate any applicable copyright law, the carrier may instead comply with this section by providing a clear, written explanation of the policy as it applies to the provider. 11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

11. All carriers shall establish, in writing, their claims payment dispute mechanism and shall make this information available to providers.

C. Without limiting the foregoing, in the processing of any payment of claims for health care services rendered by providers under provider contracts and in performing under its provider contracts, every carrier subject to regulation by this title shall adhere to and comply with the minimum fair business standards required under subsection B, and the Commission shall have the jurisdiction to determine if a carrier has violated the standards set forth in subsection B by failing to include the requisite provisions in its provider contracts and shall have jurisdiction to determine if the carrier has failed to implement the minimum fair business standards set out in subdivisions B 1 and B 2 in the performance of its provider contracts.

D. No carrier shall be in violation of this section if its failure to comply with this section is caused in material part by the person submitting the claim or if the carrier’s compliance is rendered impossible due to matters beyond the carrier’s reasonable control (such as an act of God, insurrection, strike, fire, or power outages) which are not caused in material part by the carrier.

E. Any provider who suffers loss as the result of a carrier’s violation of this section or a carrier’s breach of any provider contract provision required by this section shall be entitled to initiate an action to recover actual damages. If the trier of fact finds that the violation or breach resulted from a carrier’s gross negligence and willful conduct, it may increase damages to an amount not exceeding three times the actual damages sustained.
Notwithstanding any other provision of law to the contrary, in addition to any damages awarded, such provider also may be awarded reasonable attorney's fees and court costs. Each claim for payment which is paid or processed in violation of this section or with respect to which a violation of this section exists shall constitute a separate violation. The Commission shall not be deemed to be a "trier of fact" for purposes of this subsection.

F. No carrier (or its network, provider panel or intermediary) shall terminate or fail to renew the employment or other contractual relationship with a provider, or any provider contract, or otherwise penalize any provider, for invoking any of the provider's rights under this section or under the provider contract.

G. This section shall apply only to carriers subject to regulation under this title. H. This section shall apply with respect to provider contracts entered into, amended, extended or renewed on or after July 1, 1999.

I. Pursuant to the authority granted by Section 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to implement this section.

J. If any provision of this section, or the application thereof to any person or circumstance, is held invalid or unenforceable, such determination shall not affect the provisions or applications of this section which can be given effect without the invalid or unenforceable provision or application, and to that end the provisions of this section are severable.

K. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

Section 38.2-3407.15:2. Carrier contracts: required provisions regarding prior authorization

A. As used in this section, unless the context requires a different meaning:

"Carrier" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Prior authorization" means the approval process used by a carrier before certain drug benefits may be provided.

"Provider contract" has the same meaning ascribed thereto in subsection A of § 38.2-3407.15.

"Supplementation" means a request communicated by the carrier to the prescriber or his designee, for additional information, limited to items specifically requested on the applicable prior authorization request, necessary to approve or deny a prior authorization request.

B. Any provider contract between a carrier and a participating health care provider, or its contracting agent, shall contain specific provisions that:

1. Require the carrier to, in a method of its choosing, accept telephonic, facsimile, or electronic submission of prior authorization requests that are delivered from e-prescribing systems, electronic health record systems, and health information exchange platforms that utilize the National Council for Prescription Drug Programs' SCRIPT standards;

2. Require that the carrier communicate to the prescriber or his designee within 24 hours of submission of an urgent prior authorization request to the carrier, if submitted telephonically or in an alternate method directed by the carrier, that the request is approved, denied, or requires supplementation;

3. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a fully completed prior authorization request, that the request is approved, denied, or requires supplementation;

4. Require that the carrier communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within two business days of submission of a properly completed supplementation from the prescriber or his designee, that the request is approved or denied;
5. Require that if the prior authorization request is denied, the carrier shall communicate electronically, telephonically, or by facsimile to the prescriber or his designee, within the timeframes established by subdivision 3 or 4, as applicable, the reasons for the denial;

6. Require that prior authorization approved by another carrier be honored at least for the initial 30 days of a member's prescription drug benefit coverage, subject to the provisions of the new carrier's evidence of coverage, upon the carrier's receipt from the prescriber or his designee, of a record demonstrating the previous carrier's prior authorization approval;

7. Require that a tracking system be used by the carrier for all prior authorization requests and that the identification information be provided electronically, telephonically, or by facsimile to the prescriber or his designee, upon the carrier's response to the prior authorization request; and

8. Require that the carrier's prescription drug formularies, all drug benefits subject to prior authorization by the carrier, all of the carrier's prior authorization procedures, and all prior authorization request forms accepted by the carrier be made available through one central location on the carrier's website and that such information be updated by the carrier within seven days of approved changes.

C. The Commission shall have no jurisdiction to adjudicate individual controversies arising out of this section.

D. This section shall apply with respect to any contract between a carrier and a participating health care provider, or its contracting agent, that is entered into, amended, extended, or renewed on or after January 1, 2016.

E. Notwithstanding any law to the contrary, the provisions of this section shall not apply to:


2. The state employee health insurance plan established pursuant to § 2.2-2818;

3. Accident only, credit or disability insurance, long-term care insurance, TRICARE supplement, Medicare supplement, or workers' compensation coverage's;

4. Any dental services plan or optometric services plan as defined in § 38.2-4501; or

5. Any health maintenance organization that (i) contracts with one multispecialty group of physicians who are employed by and are shareholders of the multispecialty group, which multispecialty group of physicians may also contract with health care providers in the community; (ii) provides and arranges for the provision of physician services by such multispecialty group physicians or by such contracted health care providers in the community; and (iii) receives and processes at least 85 percent of prescription drug prior authorization requests in a manner that is interoperable with e-prescribing systems, electronic health records, and health information exchange platforms.
Point of Care

About Point of Care

Participating Facilities have fast, easy access to information about Covered Individuals and Claims – Monday through Saturday 6 a.m. until 12 midnight and Sunday from 6 a.m. to 1 p.m. and 8 p.m. until 12 midnight. Simply log on to www.Anthem.com and click on Point of Care. You can access the following types of information:

- Eligibility & Benefits
- Claims Inquiry
- Claim Adjustment Request
- Weekly Remittances
- Authorizations (Inquiry & Create)
- Proof of Loss Claim Error Notification Report
- On-line Portal Registration

Other valuable resources (anthem.com)

Anthem.com offers an overview page that includes Medical Coverage Guidelines. In addition, information regarding the following is also available on our web site:

- EDI Information
- Utilization Review Information
- Remit remark codes
- Preventive Care List
- Health Services Review
- Commonly Used Forms
- 360° Health
- Health Programs
- Plans and benefits
- Health care Decision Tool
# Professional Provider Billing Guidelines

<table>
<thead>
<tr>
<th><strong>WHO</strong></th>
<th>Anthem Blue Cross and Blue Shield in Virginia (VA) defines “professional providers” as health care providers who submit Claims for professional services rendered to Covered Individuals using the Health Insurance Portability &amp; Accountability Act's (HIPAA) compliant 837 electronic Health Care Claim Professional transaction, or the standard health care CMS-1500 paper Claim form.</th>
</tr>
</thead>
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<tr>
<td><strong>WHAT</strong></td>
<td>These Professional Provider Billing Guidelines are intended to inform professional providers of Anthem’s Claim submission requirements that are in addition to those set forth in the HIPAA 5010 national standards as described in our “Companion Guide” document located on our EDI website at <a href="http://www.anthem.com/edi">http://www.anthem.com/edi</a>, and the CMS-1500 Claim form standards set forth by the National Uniform Claim Committee as described on their website at <a href="http://www.nucc.org/">http://www.nucc.org/</a>.</td>
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<tr>
<td><strong>WHY</strong></td>
<td>Anthem participating providers are contractually obligated to file insurance Claims for Covered Individuals for Covered Services; therefore, cannot request payment in full upfront, but can collect any applicable Cost Share, i.e. copayments, coinsurance and/or deductible amounts. Please note that coinsurance/deductible amounts are variable and are based on the Covered Individual’s Health Benefit Plan.</td>
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| **WHEN** | All Claims for Covered Services rendered to Anthem Covered Individuals must be submitted within 12 months of the date of service, whether Anthem coverage is primary or secondary. In situations where Anthem is secondary but the primary payer takes over 12 months from the date of service to process their Claim, Anthem may waive this 12-month timely filing requirement on a case-by-case basis.  

In situations when the Anthem Claim is rejected and noted on the provider’s “Claims Error Notification Report”, the timely filing clock does not stop; therefore, even if the original Claim was submitted timely, the resubmission may deny for timely filing.  

When the provider submits Claims within 12 months and Anthem requests additional information, this information should be provided within 30 days or before the expiration of the 12 month period. |
| **WHERE** | Anthem in VA currently receives over 93% of Claims electronically. Providers who submit electronically, whether directly or through a clearinghouse/vendor, are able to assign their own “payer” number for electronic transmissions to Anthem. Anthem receives the 837s, performs edits, and then routes them to the appropriate platform for processing.  

For the remaining 7% of Claims submitted on paper for all Anthem products (whether group or individual; whether Par, PPO, HMO, Medicaid or Medicare), and for any other paper correspondence regarding Anthem Covered Individuals, the mailing address is:  

**Anthem Blue Cross and Blue Shield**  
P.O. Box 27401  
Richmond, VA 23279  

**BLUECARD®**  
As a member of the national Blue Cross and Blue Shield Association's BlueCard® program, Anthem (VA) is considered the local or HOST plan. The HOME plan is the state/plan from which the Covered Individual's policy originates. For out-of-state “Blue” Claims, providers submit 837 electronic Claims to Anthem’s payer number or mail to the same Anthem address above for paper Claims, with the following important exceptions:  

1.) If a Virginia (VA) provider has signed a direct contracting agreement with another “Blue” plan that is contiguous to VA, i.e. NC, KY, TN, WVA, MD, and sees a Covered Individual whose policy originates from that state, the VA provider must file the Claim with that Plan. |
### BLUECARD ® (CONTINUED)

2.) If a VA provider is located in the Northern VA/Washington, DC area, the determination of where to send the Claim is based upon three factors: the provider’s agreement status with Anthem in VA and with CareFirst in DC, the Covered Individual’s network (Par, PPO, etc.), and the location where treatment was rendered. This is relative to state Route 123, which is the official boundary that defines the Anthem and CareFirst Service Areas. *(See the Northern VA/Washington, DC Service Area Chart.)*

Anthem-contracting providers may only charge a Covered Individual for their Cost Share at the time of service, i.e. copayment, coinsurance, deductible.

Full payment upfront cannot be requested, even if the Covered Individual’s HOME plan is from another state and the ID card contains a suitcase logo (which signifies the policy as having benefits under the BlueCard® program).

The HOME plan is responsible for a Covered Individual's eligibility and benefits, as well as medical policy/authorizations. To verify this information pre-service, call 1-800-676-BLUE and follow the menu prompts.

The HOST plan (Anthem) is responsible for receiving Claims and remitting the outcome. To inquire about Claim status, adjustments, resubmissions and requests for additional information post-service, call 1-800-533-1120 and follow the menu prompts.

### BLUECARD ® for CERTAIN ANCILLARIES

The following Claims filing requirements comply with a national Blue Cross and Blue Shield Association mandate for certain ancillary provider types. Other Ancillary provider types, including Home Infusion therapy providers for example, are not subject to this requirement:

- **Independent Clinical Laboratory (Lab)** – Claims must be filed to the BC/BS Plan where the specimen is collected.

- **Durable/Home Medical Equipment and Supplies (DME)** – Claims must be filed to the BC/BS Plan where the equipment was delivered or where it was rented/purchased at a retail store.

- **Specialty Pharmacy** – Claims must be filed to the BC/BS Plan where the prescribing/ordering physician is located.

### FEP

Relative to the state Route 123 boundary but different from the BlueCard® rules, Northern VA/DC providers who see Covered Individuals carrying the Federal Employee Health Benefit Program (FEHBP or FEP) ID card must send these Claims to either Anthem (VA) or CareFirst (DC) based **solely** on the Service Area in which treatment is rendered.

### FEP for CERTAIN ANCILLARIES

Claims for members enrolled in the Blue Cross Blue Shield Service Benefit Plan, also known as FEP, are not subject to the aforementioned BCBSA mandate for ancillary claims filing.

### HOW

Anthem requires that providers use the most current versions of these coding manuals:

- **CDT-** Current Dental Terminology (American Dental Association)
- **ICD-** International Classification of Diseases (Version 9; Version 10 when mandated)
- **HCPCS-** Healthcare Common Procedure Coding System

Anthem requires all professional providers to submit all Claims using their individual 10-digit National Provider Identifier (NPI) number.
<table>
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<th>Exceptions: These provider specialties may submit Claims using their group or organizational NPI number if designated by Anthem as &quot;group exempt billable&quot;: Anesthesiologists, Emergency Medicine physicians, Hearing Aid specialists, Hospitalists, Intensivists (adult and pediatric), Laboratories, Neonatologists, Pathologists, Private Duty Nursing providers, Radiologists, and Therapy providers (physical, speech, occupational). Anthem follows the Standard Transactions and Code Sets final rule for the Administrative Simplification provision of the Health Insurance Portability and Accountability Act (HIPAA).</th>
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<tbody>
<tr>
<td>EDI</td>
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<tr>
<td>837P ELECTRONIC</td>
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</table>
The benefits of electronic Claims submission include cleaner Claims, reduced administrative costs (paper, ink, postage), faster notification of rejected Claims, and faster payment.

Electronic Claim submitters can receive Electronic Remittance Advice (ERA) and Electronic Funds Transfer (EFT), the process by which payments are wired directly to the provider's designated bank account.

Anthem applies the same edits to paper and electronic Claims. Paper Claim submitters should review the EDI web information if considering moving to electronic transactions.

**ANTHEM REQUIREMENTS FOR THE CMS-1500 PAPER CLAIM FORM INCLUDE:**

1. Complete all blocks/fields to ensure all pertinent information that Anthem may need in processing is not overlooked.

2. Be sure to insert the rendering provider's individual NPI number in blocks 24J and 33a (or the group or organizational NPI number if deemed “group exempt billable” as previously described).

3. Claims should be computer printed or typed; not handwritten, which creates the highest degree of errors, due both to illegibility and scanning irregularities with our Optical Character Recognition (OCR) equipment.

4. Must submit only original CMS-1500 Claim forms with the correct red "drop-out" ink color; photocopies of blank CMS-1500 forms will not be accepted.

5. Carefully align forms in the printer or typewriter to ensure characters do not fall on or over the line of any given block.

6. Use UPPERCASE characters only; use font styles only of ARIAL, COURIER NEW, or TIMES NEW ROMAN in either 10 or 12 characters per inch; do not use ITALICS.

7. Use numbers ("0" zero, "1" one) and letters ("0", "l") correctly.

8. Do not type a slash over a zero.

9. Do not use red ink or a highlighter anywhere on the Claim.

10. Do not add handwritten notes anywhere on the Claim.

11. Enter only one Claim item per Claim line (no more than six lines per Claim). If more than six Claim lines for the same Covered Individual are needed, use a second Claim and indicate on the top of each page, “page 1 of 2, etc.” and staple together.

12. Use white carbon correcting paper or white self-stick correction tape when correcting mistakes; do not use liquid correcting fluid.

13. File Claims with dollar amounts unless you are submitting CPT Category II codes, which are used for tracking purposes only and carry no reimbursement value.

To avoid denials for duplicate Claims, never submit a Claim twice for any given service unless resubmitting a corrected Claim for one that appears on your “Claim Error Notification Report”, or if Anthem makes such a request.
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<th>CLAIM REOPEN REQUESTS</th>
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<tr>
<td>When changes or additions are required for a Claim that has been finalized and reported on the remittance, or there is a question regarding the outcome of a Claim, submit an <strong>Anthem #151 Claim Information/Adjustment Request</strong> either electronically through the secure online provider portal or on paper by downloading this form from the provider portal.</td>
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<tr>
<td><strong>ELECTRONICALLY:</strong> When viewing a particular Claim on Point of Care, from the “Claims Inquiry” screen select the “Create a 151” function. The next screen will contain the demographic information from the Claim, leaving remarks/instructions to be added, and then submit online. This method can be used for requests that will not require accompanying supporting documentation. If office or operative notes or other pertinent attachments are required, simply download the completed #151, attach it to any supporting documentation, and mail it to Anthem (same address as previously described under WHERE).</td>
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<tr>
<td><strong>PAPER:</strong> A blank #151 form is available to download from the Virginia provider open portal by following these <strong>directions:</strong> Go to <a href="http://www.anthem.com">http://www.anthem.com</a>; then PROVIDERS, then VA and Enter; then Answers @ Anthem, then Provider Forms. Complete the entire form and then mail it and any necessary supporting documentation to Anthem (same address as previously described under WHERE).</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Receipt by Anthem of #151 requests is preferred within 30 days of the Claim adjudication (process) date. #151 requests will not be considered if received after 12 months from the Claim adjudication date.</td>
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<th>MODIFIERS</th>
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<td>Anthem accepts and processes all HIPAA compliant modifiers, both CPT numeric and HCPCS alpha; however, their use does not guarantee payment. Some modifiers impact reimbursement; others are informational only and are considered revenue neutral. Anthem makes the determination as to how modifiers are considered during Claim processing.</td>
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<tr>
<td>Anthem has deemed certain modifiers that <strong>affect reimbursement.</strong> These are described in detail in the “Plan Compensation Schedule Attachment” of the provider agreement.</td>
</tr>
<tr>
<td>Anthem has deemed certain modifiers that <strong>require supporting documentation;</strong> when these are billed (837P or on paper), this documentation must be included with the original Claim. These modifiers are also described in detail in the “Plan Compensation Schedule Attachment” of the provider agreement.</td>
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<th>CLAIM ATTACHMENTS</th>
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<tr>
<td>Details regarding the process of sending paper attachments for 837P, 837I, and 837D electronic Claims (known as “PWK” for paperwork) are found in the EDI section of the website: Go to <a href="http://www.anthem.com/edi">http://www.anthem.com/edi</a>; select Virginia; select Documents; select Companion Guide; scroll down to Section B; then select 837P, 837I, or 837D <strong>HealthCareClaim</strong> and look for PWK. The process of sending supporting documentation with a paper CMS-1500 is to simply staple the additional page(s) to the original Claim and mail to Anthem (same address as previously described under WHERE).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>COB</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Coordination of Benefits (COB)</strong> is the cooperative effort whereby a Covered Individual or dependent is insured by more than one Health Benefit Plan, and the payers involved work together to prevent duplication of payment for services.</td>
</tr>
<tr>
<td>When Anthem provides coverage as the secondary payer, Anthem will administer payment for the Covered Service in accordance with the COB rules set forth in the Covered Individual’s Contract. Anthem providers will accept such payment determination as fulfilling Anthem’s payment obligation under their Anthem Agreement. Anthem providers may collect from the primary payer the amount allowed by that payer for the Covered Service. However, providers may not collect any amount from the Covered Individual if such amount, when added to the amounts collected from both the primary and secondary payers, would cause the total reimbursement to exceed the amount allowed for the Covered Service under Anthem’s Plan</td>
</tr>
</tbody>
</table>
Fee Schedule.

Providers are required to report the other payer’s Claim payment information, i.e. amount billed, amount allowed, amount paid, in the appropriate areas within the electronic 837 Claim transaction (see EDI section previously described for directions to the Guide), or in the appropriate blocks on the CMS-1500 paper Claim form.

Sending a hardcopy of the primary payer’s Explanation of Payment/Explanation of Benefits (EOP/EOB) is not necessary as long the primary payer’s Claim payment information is reported on the Anthem secondary Claim as described above.

See the Medicare section of this document for “cross-over” information.

**GENERAL GUIDELINES:**

If a Covered Individual holds a contract for a group insurance plan and is listed as a dependent on another health insurance plan, the plan for which the Covered Individual is a contract holder is primary; the other is secondary.

For covered dependent children, the plan of the parent whose birthday falls earliest in the year is primary (“Birthday Rule”).

For covered dependent children with separated or divorced parents, if a court has established which parent is responsible for the child’s healthcare expenses, that parent’s plan is primary. When financial responsibility has not been established, the plan covering the parent with legal custody is primary.

A group plan that does not have a COB provision will be primary over one that does.

If a Covered Individual holds two or more group insurance plans, the policy that considers the Covered Individual an active employee is primary. If the Covered Individual is active under both policies, the policy that has been active longer is primary.

### REFUNDS

Providers who experience an overpayment for any reason may submit a #151 Claim Information/Adjustment Request to direct Anthem to retract the amount from a future remittance.

Providers who prefer to send Anthem a check may download an online form: Go to [http://www.anthem.com/](http://www.anthem.com/); select PROVIDERS, select VA; select Answers @ Anthem; under Tools & Resources, select Provider Forms; then select the Provider Overpayment Form.

For erroneous or duplicate Claim payments under the Federal Employee Health Benefit Program (FEP), 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.

### APPEALS

Refer to this online chart for definitions and the appropriate process to use: [http://www.anthem.com/provider/va/f4/s0/t0/pw_ad085695.pdf?refer=ahpprovider&state=vat](http://www.anthem.com/provider/va/f4/s0/t0/pw_ad085695.pdf?refer=ahpprovider&state=vat)

Refer to this online document for details of the Policy/Procedure: [http://www.anthem.com/provider/va/f4/s0/t0/pw_ad085694.pdf?refer=ahpprovider&state=vat](http://www.anthem.com/provider/va/f4/s0/t0/pw_ad085694.pdf?refer=ahpprovider&state=vat)

### MEDICAID

Due to Health Care Reform legislation and the requirement for Medicaid Managed Care Organizations (MCOs) to provide utilization data for the Medicaid Drug Rebate Program, Claims for all drugs dispensed in a physician’s office or other outpatient setting for Anthem’s Medicaid HMO, Anthem Healthkeepers Plus, require the **National Drug Code (NDC) number and the drug-related HCPCS physician administration code**.
Virginia Vaccines for Children (VVFC) is a vaccine supply program, which is state-operated and federally-funded. VVFC supplies federally purchased vaccines at no cost to VVFC-enrolled providers to be administered to eligible members. Providers billing VVFC procedure codes are reimbursed for vaccine **administration costs only**. In order to receive the vaccines, Provider must enroll in VVFC and use VVFC vaccines for Medicaid Covered Individuals who are eligible for them. The reimbursement for the **vaccine administration** will be based upon the Medicaid HMO Allowance. Provider must follow the Virginia Medicaid billing guidelines when administering vaccines to a Medicaid Covered Individual eligible for VVFC.

<table>
<thead>
<tr>
<th>MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem Medicare Supplement (MediGap) policies are secondary coverage when Medicare is primary coverage.</strong> The Medicare Part B intermediary (currently Palmetto in Virginia) receives the provider’s Claim, processes it and “crosses it over” to Anthem. In most cases, the provider will not have to submit the secondary Claim to Anthem; notification of this “cross-over” appears on the provider’s Explanation of Medicare Benefits (EOMB).</td>
</tr>
<tr>
<td>If the Medicare EOMB does not indicate the cross-over, providers should wait 30-45 days before submitting a secondary Claim to Anthem.</td>
</tr>
<tr>
<td><strong>Anthem Medicare Advantage (MAPPO) policies include primary and secondary coverage combined into one policy. Providers submit these Claims to Anthem only.</strong></td>
</tr>
<tr>
<td>The “Welcome to Medicare” visit for new Medicare enrollees and the Annual Wellness Visit (AWV) should be coded using the CMS recommended HCPCS codes; all other services should be coded as any Anthem Covered Individual’s Claims are coded.</td>
</tr>
<tr>
<td>Directions to Medicare information on the provider website: Go to <a href="http://www.anthem.com/">http://www.anthem.com/</a>; select VA; under Plans &amp; Benefits; select Medicare Eligible; then scroll to links for VA information.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OTHER GENERAL INFORMATION OF IMPORTANCE FOR ALL CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>HEALTH CARE IDENTIFICATION NUMBER:</strong> Always indicate the Covered Individual's complete HCID number, including the alpha prefix and suffix (when applicable); exactly as shown on the ID card, on all Claims.</td>
</tr>
<tr>
<td><strong>COLLECTING COST SHARES:</strong> Anthem providers may only ask for payment from Covered Individuals for Covered Services that includes any of the following (based on the Covered Individual's contract): copayment, coinsurance, and/or deductible amounts, at the time of service. Asking for payment in full upfront is prohibited.</td>
</tr>
<tr>
<td>The total amount an Anthem provider may collect for any “Covered Service” cannot exceed the lesser of Anthem’s allowance or the provider’s charge. Anthem providers must write-off any amount exceeding this, or any amount for which a Covered Individual is “held harmless” as defined in the Covered Individual and provider agreements.</td>
</tr>
<tr>
<td><strong>RENDERING NOT MEDICALLY NECESSARY OR INVESTIGATIONAL/NON-COVERED SERVICES:</strong> Anthem providers may also collect from Covered Individuals for services deemed “not medically necessary or investigational” when rendered to non-HMO Covered Individuals and services deemed “non-covered” when rendered to HMO Covered Individuals. This is true only if provider advises the member in writing before the service is rendered.</td>
</tr>
<tr>
<td>The provider must have the Covered Individual sign a statement that includes the date, a description of the specific service, the approximate charge for that service, and the fact that the Covered Individual understands their payment responsibility; otherwise, the provider may not bill the Covered Individual for such services.</td>
</tr>
<tr>
<td>Without this signed statement, the Covered Individual is held harmless when Anthem denies the claim and the provider must write off the charge.</td>
</tr>
<tr>
<td>OTHER GENERAL INFORMATION OF IMPORTANCE FOR ALL CLAIMS CONTINUED</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>NOTE:</strong> A generalized statement that the Covered Individual shall be responsible for any charges not covered by Anthem or health maintenance organization is not sufficient.</td>
</tr>
<tr>
<td><strong>RECEIVING A REQUEST FOR RECORDS:</strong></td>
</tr>
<tr>
<td>When Anthem requests medical information from a provider, a timely return of seven (7) days from the request for those records is recommended in order to expedite Claims adjudication.</td>
</tr>
<tr>
<td><strong>CLAIM SUBMISSION ACCURACY:</strong></td>
</tr>
<tr>
<td>Submitting false or improper Claims knowingly is considered fraud; submitting improper Claims unintentionally is considered abuse. Anthem providers must ensure compliance with their Claims submission, whether done “in-house” or subcontracted to an outside entity who submits on their behalf.</td>
</tr>
</tbody>
</table>
WHERE TO FILE BlueCard® CLAIMS for PROVIDERS in NORTHERN VA/DC AREA:

**ANTHEM's Service Area:** The entire state of Virginia *EXCEPT:*
- City of Alexandria
- Arlington County
- Fairfax County that is east or inside of Route 123 (including Fairfax City and the town of Vienna).

**Care First's Service Area:** The District of Columbia, Montgomery and Prince George’s Counties in Maryland, and:
- City of Alexandria
- Arlington County
- Fairfax County that is east or inside of Route 123 (including Fairfax City and the Town of Vienna).

**INSTRUCTIONS FOR USING THIS GRID:**

1. First, find the Plan’s Service Area (as described above) in which your patient *received treatment*, not where your claims/billing office is located.

2. Next, determine your contracting status for each Plan as it pertains to the specific network in which the patient has benefits, i.e. Traditional, PPO, HMO, and whether you are contracting with that network. Select the appropriate scenario number, either #1, #2 or #3, in the boxes within that service area.

3. Now, determine which Plan issued the patient’s coverage (see column headers for VA, DC and “other”) and follow the grid to the appropriate box to see which Plan should receive your claim.

**NOTE:** These rules apply to BlueCard® claims only. FEP claims must be sent based solely on the location of treatment. Remote Providers (Lab, DME, Specialty Pharmacy) should follow the national BCBSAmandate previously referenced.

<table>
<thead>
<tr>
<th>If your Office Location where patient is treated in</th>
<th>And, Your Provider Contract Status by network is</th>
<th>For Anthem (VA) cardholders, SEND CLAIMS TO:</th>
<th>For CareFirst (DC) cardholders, SEND CLAIMS TO:</th>
<th>For cardholders of all other Blue, SEND CLAIMS TO:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem Blue Cross and Blue Shield</strong></td>
<td>YES w/VA #1 NO w/DC</td>
<td>ANTHEM</td>
<td>ANTHEM</td>
<td>ANTHEM</td>
</tr>
<tr>
<td><strong>SERVICE AREA</strong></td>
<td>YES w/VA #2 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>ANTHEM</td>
</tr>
<tr>
<td>(West/Outside of Route 123)</td>
<td>NO w/VA #3 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>ANTHEM</td>
</tr>
<tr>
<td><strong>CareFirst Blue Cross Blue Shield</strong></td>
<td>YES w/VA #1 NO w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
</tr>
<tr>
<td><strong>SERVICE AREA</strong></td>
<td>YES w/VA #2 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
</tr>
<tr>
<td>(East/Inside of Route 123)</td>
<td>NO w/VA #3 YES w/DC</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
</tr>
</tbody>
</table>
Utilization Management Program and Plan (the “Program”)

Utilization Management Program and Plan

This document describes the prospective review, Continued Stay Review, Care Coordination, Discharge Planning and retrospective review activities of Anthem (and its designees) with providers of health care. Providers agree to participate in this Program as it may be amended, modified or updated from time to time. By participating in this Program, the Provider agrees to strictly adhere to and comply with all of the terms, requirements, and guidelines of this document. Providers of health care may include Primary Care Physicians, specialists, nurse practitioners, physician assistants, certified registered nurse anesthetists, behavioral health care professionals, private duty nursing agencies, and medical equipment suppliers.

I. Introduction

Because the escalation of health care costs is a national and local issue, Anthem considers effective medical management an essential process, strategically directed at maintaining quality health care while curtailing unnecessary costs associated with inappropriate consumption of health care resources.

The Program affords the following opportunities to Provider and Covered Individuals:

A. The Program limits the potential for and/or the number of retroactive denials.
B. The Program, if adhered to, significantly reduces the need for requesting additional medical information to evaluate and justify health care resource coverage.
C. The Program promotes compliance with policy benefit provisions, resulting in sound health care delivery with appropriate compensation for services rendered.

Contact Information:

Website – http://www.Anthem.com

Telephone Numbers:

1-800-533-1120  Anthem Blue Cross and Blue Shield Provider Data Touch Interactive Voice Response System see attached “Data Touch Interactive Voice Response (IVR)” brochure on page XX

Group Plan Services Operations
Pharmacy Management
Medical Management

1-800-321-8318  Anthem Blue Cross and Blue Shield Individual or Government business

1-800-421-1883  HealthKeepers, Inc. and Anthem HealthKeepers Plus

1-757-326-5270  Anthem HealthKeepers Plus

1-800-991-6045  Behavioral Health

1-866-797-9884  Medicare Advantage

Anthem’s Point of Care system is available to initiate or check status of a Health Services Review, Admission Review or Specialty Care Review. Instructions on how to register for Point of Care are available at www.Anthem.com or through your provider consultant. (Point of Care is not available for Medicare Advantage).

In addition to checking claims status, eligibility and benefits, the features below are available on Point of Care:

• Primary Care Physicians can submit requests for Specialty Care Reviews and fax related information to specialists and hospitals.
• Hospitals and specialists can view Specialty Care Reviews for their patients.
• Hospitals and Attending Providers can submit requests for Admission Reviews.
• Utilization Review/Case Management Departments and Attending Providers can update clinical information and ask for extension of hospital stays.
• Providers can view status of Health Services Reviews (certification of outpatient procedures).

NOTE: Anthem will be migrating its claim processing and utilization management (UM) systems as part of an enterprise initiative to consolidate the multiple platforms that are in existence today. UM and claims functionality currently available in Point of Care may be limited in the future based on the interfacing capabilities of supporting systems.

II. Definitions

The following terms, as used in this document, shall have the meanings shown below:

1. Admission Review shall mean a review that determines whether inpatient services and inpatient transfers from one hospital to another are a Covered Service and are Medically Necessary.

2. Attending Provider shall mean the Provider ordering tests and/or procedures for a Covered Individual as an outpatient or a Provider having the primary responsibility for the care of the major condition or diagnosis of a Covered Individual in an inpatient setting.

3. Care Coordination refers to the activities conducted by Anthem clinical staff that occur to evaluate any ongoing care gaps and help to improve the inpatient care a Covered Individual receives.

4. Continued Stay Review shall mean the daily activities on cases by Anthem clinical staff while Covered Individuals are admitted in a facility.

5. Discharge Planning refers to Provider-facing interactions conducted by Anthem UM clinical staff that ensure a Covered Individual's care needs are accommodated after hospitalization.

6. Health Services Review shall mean an Anthem review that determines whether outpatient services are a Covered Service and are Medically Necessary.

7. Non-Covered Services shall mean Health Services and supplies which are not covered under the terms and conditions of the Health Benefit Plan under which a Covered Individual is covered or enrolled.

8. Primary Care Physician shall mean the physician who provides the primary health care services for a Covered Individual and coordinates other Covered Services when indicated.

9. Specialty Care Review shall mean a Primary Care Physician's recommendation for a patient to receive outpatient services from another in-network Provider (provider or facility).

10. The Program shall mean Anthem or its designees who perform the utilization management services described in this document.

III. General Requirements of the Provider

The Provider shall fully and diligently cooperate with and abide by all elements of the Program, including but not limited to the following components of the Program: Specialty Care Review, Health Services Review, and telephonic and/or onsite Admission Review, Continued Stay Review, Care Coordination, and Discharge Planning. The Provider agrees to provide medical information in a timely manner to the Program for determining the Medical Necessity of the Covered Individual's care. The Covered Individual and Anthem are not responsible for payment for any medical services that are delivered in violation of the requirements of this Program.

The current list of services requiring a Health Services Review is available to Providers online at http://www.anthem.com/, through Anthem's Point of Care system or by calling Medical Management at the number in the Contact Information in Article I.

The components of the Program are described in more detail under the following articles contained in this document.
Articles:

- Article V Attending Provider Rights and Responsibilities for Specialty Care Review
- Article VI Attending Provider Rights and Responsibilities for Admission Review
- Article VII Attending Provider Rights and Responsibilities for Continued Stay Review, Discharge Planning, and Care Coordination
- Article VIII Attending Provider Rights and Responsibilities for Medical/Surgical Outpatient Health Services Review
- Article IX Attending Provider Rights and Responsibilities for Behavioral Health Care Outpatient Health Services Review
- Article X Provider Rights & Responsibilities for Drugs Requested through Covered Individual's Medical Benefit
- Article XI Provider Rights & Responsibilities for Private Duty Nursing Review
- Article XII Provider Rights & Responsibilities for Audit Activities

IV. General Information

A. To obtain general patient eligibility and coverage information and patient-specific requirements for Specialty Care Review, Admission Review and Health Services Review, the Provider may call service operations at the numbers listed in the Contact Information in Article I.

B. To have a particular service reviewed for Medically Necessity, the Provider may submit a request through Anthem's Point of Care system or call Medical Management at the number listed in the Contact Information in Article I. These phone lines are operational Monday through Friday during normal business hours with the exception of Anthem's designated holidays. Anthem will comply with any state or federal mandate with requirements that exceed the hours of operation as otherwise stated in the Program.

C. The Program applies to Medical Necessity review as described. It applies in entirety to all Covered Individuals unless otherwise noted. Admission Reviews, Continued Stay Reviews, Health Services Reviews and retrospective audits are for confirming Medical Necessity. All other provisions of any Health Benefit Plans, including but not limited to the other coverage exclusions, limitations on days, and appropriate waiting periods, shall continue to be enforced and are not subject to the Program.

D. If services rendered to a Covered Individual are determined by Anthem to be not Medically Necessary or Investigational, or, in the case of an HMO Covered Individual, not covered for any reason then Provider of professional services shall make no charge and render no bill to the Covered Individual for such services, and neither Anthem nor any Covered Individual shall have any payment responsibility for those services except as otherwise provided in (a) and (b), below.

a. Covered Individuals may only be held responsible for payment of the Non-Covered Service referenced above if, before the services are rendered, the Covered Individual signs an acknowledgment and consent form as specified in the Agreement.

b. Further, Anthem may cover certain of the non-Medically Necessary or Investigational Services referenced above in connection with Covered Individuals enrolled under fully-insured Health Benefit Plans and under certain self-insured or at-risk Health Benefit Plans that adopt into their health plan, in writing, the exception described in this subsection IV. D. Specifically, if a Covered Individual receives the non-Medically Necessary Services or Investigational services, the following physician services rendered to that Covered Individual will not be denied by Anthem in spite of the denial of coverage for the overall services:

Services rendered in (i) an inpatient hospital; (ii) inpatient psychiatric facility setting; or (iii) a psychiatric partial inpatient facility setting:
• by physicians who do not control whether the Covered Individual was treated on an inpatient basis, such as pathologists, radiologists, anesthesiologists, and consulting physicians, and

• by the Attending Provider, other than inpatient evaluation and management services provided to the Covered Individual.

  - Inpatient evaluation and management services include routine visits by the Attending Provider for purposes such as reviewing patient status, test results, and patient medical records.

  - Inpatient evaluation and management visits do not include surgical, diagnostic, or therapeutic services performed by the Attending Provider.

Services rendered in an (i) outpatient hospital setting (ii) Emergency room or (iii) ambulatory surgery setting by pathologists, radiologists or anesthesiologists. (However, this exception, does not apply if and when any such pathologists, radiologists or anesthesiologists assumes the role of Attending Provider.)

E. Under this Program, audit activity may include a review of any or all of the following: Medical Necessity, charges, diagnosis and other coding, and documentation of services rendered. See Article XII for additional details.

F. Any references made in this document to Program will include any review agents engaged by the Program to perform Medical Necessity and audit reviews of services rendered by Providers and their staff. Therefore, the same cooperation afforded the Program will also be expected for any of its agents.

G. The Program shall have reasonable access to medical records of Covered Individuals as needed for utilization management or quality improvement activities. Photocopies of records or review of such records requested by the Program shall be supplied without charge by the Provider. Any services ordered and not documented as having been performed in the appropriate medical records will not be reimbursed. Documentation should reflect who rendered what service, why, when and to whom.

Photographs submitted as part of the Admission Review or Health Services Review process will not be returned to the Provider.

See the applicable attachments for Documentation Guidelines:

Attachment A - Patient Medical Record Documentation Standard and Medical/Surgical Record Documentation Standards – Inpatient and Outpatient Hospital

Attachment B - Behavioral Health Documentation Standards

H. To ensure the patient receives the highest level of benefits or any benefit for Covered Individuals, Providers should refer patients to Network/Participating Providers. The Program may certify Medically Necessary specialized Covered Services that are not available in the provider network and that can only be rendered by a non-network Provider (inpatient or outpatient), provided that these services are approved in advance through the Program. However, any service available in the network must be rendered by a Network/Participating Provider in order to receive the highest level of benefits, with the exception of Emergency services as defined by the Program and, for HMO Covered Individuals, out of area urgent care services, which will be certified at the in-network benefit level wherever they are rendered.

Urgent care situations are usually marked by the rapid onset of persistent or unusual discomfort associated with an illness or injury. Examples of an urgent care situation may be a high fever or sprain.

I. Anthem ensures the confidentiality of patient-specific medical records and information in accordance with applicable state and federal laws and regulations. A breach of confidentiality by Anthem associates may result in disciplinary action up to and including termination of employment. Information requested during the Health Services Review process is limited to patient-specific information necessary for proper adjudication of the claim and used solely for the purposes of medical management activities. It is shared only with those individuals and entities that have authority to receive such information. All medical record information submitted to Anthem will be maintained for a period of ten years.
V. Attending Provider Rights & Responsibilities for Specialty Care Reviews

If a Specialty Care Review is required by the Covered Individual’s Health Benefit Plan, then it shall be made by the Primary Care Physician on record either telephonically or electronically.

A Specialty Care Review is not a review for Medical Necessity or coverage, therefore, it is not a guarantee of payment. To help ensure correct claims payment, Primary Care Physicians must notify Anthem of Specialty Care Reviews before services are rendered or, in Emergencies, as soon as possible. The Specialty Care Review covers a number of visits or span of time for the care to take place.

For Medicare Advantage, the Program does not require the Primary Care Physician to contact Anthem for Specialty Care Reviews to Providers in the Medicare Advantage network; however, the Primary Care Physician must document such Specialty Care Review in the Covered Individual’s medical records maintained by the Primary Care Physician.

VI. Attending Provider Rights & Responsibilities for Admission Review

A. While the hospital may complete the Admission Review process as a courtesy to the Attending Provider, it is the responsibility of the Attending Provider to ensure that the Admission Review requirements are completed prior to services being rendered.

B. The Attending Provider should notify the Program at least three (3) business days in advance of an elective admission. This Admission Review process should occur during the Program's normal business hours. At the time of the notification, the Attending Provider must furnish the relevant clinical information to substantiate the need for inpatient care, as required by the Program reviewer or Anthem’s Point of Care System, and obtain Admission Review from the Program prior to any elective or planned admission of a Covered Individual.

C. For Emergency medical, surgical or behavioral health admissions, an Admission Review must be requested by the end of the first business day following the admission or within 48 hours of the admission, whichever is later.

D. Direct inpatient transfers made from one hospital to another will require Admission Review. Procedures are the same as for any Admission Review request. If the transfer is approved, Anthem will reimburse for ambulance transfer services.

E. Except in the case of an Emergency, failure to obtain an Admission Review for a hospital admission may result in denial of coverage for services provided to an HMO Covered Individual and partial or full denial of coverage if, in retrospect, the services provided to a non-HMO Covered Individual are determined not to be Medically Necessary.

F. The following information is required for the Program to complete an Admission Review:

1. Covered Individual’s identification number and Covered Individual’s name,

2. Attending Provider’s or health care provider’s name, address and phone number,

3. Hospital name, address, and telephone number,

4. Admission date and anticipated length of stay, frequency and duration of previous outpatient service(s) and medical information pertinent to determining Medical Necessity of planned care. This includes presenting clinical symptoms, relevant medical history and previous treatment, lab/radiological results, treatment plan orders, patient response to treatment and discharge needs.

VII. Attending Provider Rights & Responsibilities for Continued Stay Review, Discharge Planning and Care Coordination

A. The Attending Provider is responsible for requesting and obtaining an extension of the original approved duration of inpatient care if needed. At the time of the Admission Review, the Attending Provider will be notified of the frequency of the need for updated clinical information to certify an extension. The Attending Provider agrees to supply medical information in a timely manner to the Program for the purpose of determining the Medical Necessity of the Covered Individual’s continued care received at the hospital. This
process may be coordinated with the hospital. Approval of benefits for continued hospitalization is subject to care continuing to be Medically Necessary. If the discharge of a Covered Individual occurs after the last day covered by the Admission Review or if all inpatient days are not certified, there may be a partial or full denial of coverage if, in retrospect, the services are determined not to be Medically Necessary or Investigational.

B. The following information is needed for the Program to complete a Continued Stay:

1. Covered Individual’s identification number or Covered Individual’s name,

2. Current medical status of the patient including any lab/radiological results, current clinical symptoms, treatment plan and patient response to the treatment, discharge plans and progress toward implementation of those plans and anticipated length of stay.

C. Discharge Planning is an integral part of Admission Review and Continued Stay Review. The focus is to assess Covered Individual’s care needs during and after hospitalization in order to effect an appropriate and timely discharge and to promote appropriate alternative settings of care such as the home, skilled nursing facility or outpatient department. The Attending Provider will work with the Program nurse reviewers to facilitate the discharge needs of the patient. A Health Services Review may be required for home or other outpatient care. Admission Review is required for skilled nursing facility or rehabilitation care.

The agency/nursing home should obtain the appropriate review. Discharge services can include but are not limited to: home health nursing including physical, speech and occupational therapies provided by a home health agency; private duty nursing; and skilled nursing facility or rehabilitation services.

D. Through Care Coordination, the Program will work with the Provider to facilitate the care of Covered Individuals who have frequent and high health care expenses as a result of serious, chronic or prolonged illness or injury. In these situations, the Program may develop and implement alternatives to repeated hospitalizations or consumption of services that will provide the quality of care and appropriate level of care required by the medical condition; and use health care benefits efficiently and effectively.

VIII. Attending Provider Rights & Responsibilities for Medical/Surgical Outpatient Health Services Review

It is the responsibility of the Attending Provider to obtain a Health Services Review during the Program’s normal business hours prior to the outpatient services being rendered except in Emergency situations.

The current list of services requiring a Specialty Care Review or Health Services Review is available to Providers online at www.Anthem.com, through the Anthem’s Point of Care system or by calling Medical Management at the number listed in the Contact Information in Article I.

When a Health Services Review is required:

1. Obtain a Health Services Review prior to rendering services

   It is the responsibility of the Provider to assure that the Health Services Review requirement is completed prior to providing any services. To allow time for decision-making, this request should be made as soon as possible during normal business hours and should be accompanied by relevant clinical information to substantiate the need for the requested services, as required by the Program reviewer. This activity may be coordinated with the physician; however, failure to complete this process may result in partial or full denial of services.

2. Provide relevant medical information with request

   The following information should be submitted with the Health Services Review request to determine the Medical Necessity of Provider services.

   a. Covered Individual name, identification number and date of birth,

   b. Provider name, address and phone number,

   c. Initial date of services and intended frequency and/or duration of use,
d. Medical information pertinent to determining Medical Necessity of the requested service, including diagnosis and medical history.

The following information also should be provided as applicable:

For medical equipment suppliers, the patient’s current clinical picture including the medical need for the equipment, the patient’s current level of performance of Activities of Daily Living, and the anticipated goal that the equipment will provide, and,

For private duty nursing services, the patient’s current clinical picture including a description of the details of the skilled nursing need(s), treatment plan orders, relevant past medical history and previous treatment, educational and treatment goals, and caregiver involvement in care.

3. Obtain review confirmation

Once the medical information is received, the Program will determine if the proposed services meet Medical Necessity guidelines and therefore, can be certified for reimbursement. The provider of the service is notified as soon as the decision is made.

The Program provides a Medical Necessity decision-making process that includes use of a physician consultant or medical director in any adverse decision. In the event that Medical Necessity cannot be established, the appeals process is available. See Article XV for the appeals process. Once a service is reviewed, a certification number, the number of approved visits and the timeframe certified is communicated to the Provider for inclusion with claim submission. A certification number is generated on each initial review and is a reference number only and not a confirmation that the service is approved.

4. Obtain continuation of Services

Prior to the end of the certified period, the Provider must call to request additional services if needed. Approval of benefits is subject to care continuing to be Medically Necessary at the sole discretion of the Program. The Provider is responsible for verifying whether continued services are required and for supplying medical information in a timely manner that is pertinent to the need for continued services.

When a continuation for medical equipment is needed, the information should include the patient's current clinical status and the response to use of the equipment. The physician’s expectations and anticipated duration of services should also be supplied.

When a continuation of Private Duty Nursing services is needed, the information should include the patient’s current clinical status, treatments performed, response to treatment and progress toward transitioning the care to the caregiver/patient.

Information should be submitted in conjunction with the ordering physician and should include the physician’s expectations and anticipated duration of services. These review extensions must be conducted prior to the end of the certified period. During the Health Services Review process, the Provider agrees to work with Anthem to determine alternative cost-effective methods of receiving the quality of care the Covered Individual requires.

IX. Attending Provider Rights & Responsibilities for Behavioral Health Care Outpatient Health Services Review

Some Health Benefit Plans require a Health Services Review for outpatient psychiatric therapeutic procedures (CPT 90801-90899, and appropriate E&M codes). Coverage for outpatient behavioral services is certified when the patient’s condition or symptoms and the appropriateness of treatment are determined to be in accordance with the Program’s Behavioral Health Medical Necessity criteria. Care may be certified by Anthem’s behavioral health case manager, Anthem’s behavioral health medical or clinical directors or a psychiatric consultant representing the Program.

A. The Attending Provider shall certify any non-emergent outpatient behavioral services. Health Services Reviews can be obtained during normal Program business hours.

B. Outpatient behavioral services Health Services Review requests will not be reviewed retrospectively for more than sixty (60) days after the service is rendered, except in cases of Emergency services. If a Health
Services Review is not obtained within sixty (60) days after a non-emergent outpatient behavioral service is rendered, then, notwithstanding any provision to the contrary contained herein or in any Provider agreement, Anthem and Covered Individuals are not responsible for making any payment to the Attending Provider.

C. The initial Health Services Review decision will cover a specified number of outpatient sessions. Any additional services must be certified and a treatment plan must be sent to Anthem’s behavioral health department prior to services being rendered.

X. Provider Rights & Responsibilities for Drugs Requested Through Covered Individual’s Medical Benefits

A. A Health Services Review is required for certain drugs administered in the physician’s office, facility, infusion center or home. To find out if a drug requires a Health Services Review, the Provider may call the number listed in the Contact Information in Article I or check the requirements through Point of Care.

B. The Drug Review process is designed to promote drug use according to standard reference compendia. Medical Necessity Criteria related to specific drugs can be accessed on our website at http://www.anthem.com/ or by calling Medical Management at the number listed in the Contact Information in Article I.

C. Some Prescription drugs may be subject to quantity limits. Quantity limits are considered when the drug labeling indicates a specific number of days or an amount of drug that is considered a “duration of therapy” for most conditions. They may also be based on generally accepted standards of practice or, drug label/literature, or recommended average therapy needs for a particular condition. Providers may request the criteria by calling the number listed in the Contact Information in Article I.

D. Requests for certification may be called, faxed or entered into the electronic portal, Point of Care. Requests should include patient name, Covered Individual ID number, drug and quantity requested. Appropriate clinical information must also be provided to support the use of the medication requested. Requests without this information cannot be processed.

E. Once complete, the request is reviewed and processed. Requests for prescription drugs that do not meet Medical Necessity criteria may be forwarded to the clinical pharmacist for review. The clinical pharmacist either approves the request or refers it to a medical director or physician consultant for a decision.

F. Initial drug Health Services Review decisions are made within two business days of receipt of all necessary information. Approval letters are mailed or faxed to the Provider within two business days of the decision. Denial letters are mailed or faxed to both Covered Individual and Provider within two business days of the decision. Denial letters include information on the reconsideration and appeal process and action steps required.

G. Requests for a peer to peer or an expedited appeal may be initiated by calling the number listed in the Contact Information in Article I.

XI. Provider Rights & Responsibilities for Private Duty Nursing Review

A. Private duty nursing services are intermittent skilled nursing services that are temporary in nature and beyond the scope of care provided through home health care services. It is not intended to be provided on a permanent, ongoing basis. The purpose of private duty nursing is to assess and monitor the patient’s condition and need for ongoing private duty nursing services and provide skilled nursing care in the home on an hourly basis; to assist in the transition of care from a more acute setting to the home; and to teach competent caregivers the assumption of this care when the condition of the Covered Individual is stabilized. To receive payment as a private duty nursing benefit, all of the following criteria must be met:

The private duty nursing services must be skilled in nature, performed on a part-time or intermittent basis, ordered by a physician and Medically Necessary. See Attachment C – Guidelines for Skilled Nursing Care in the Home Setting.

Services must require the professional proficiency and skills of a registered nurse (RN) or licensed practical nurse (LPN). The decision to use an RN or LPN is dependent on the type of service required and must be consistent with the scope of nursing practice under applicable state licensure regulations.
The services are only covered when the patient’s condition generally confines him/her to home except for brief absences. See Attachment C – Guidelines for Skilled Nursing Care in the Home Setting.

The treatment plan must be certified by the Program with a written copy signed by a physician sent to the Program for approval prior to payment, if requested.

XII. Provider Responsibilities for Audit Activities

A. Under the Program, the Provider agrees to allow on-site reviews by the Program review staff to examine the medical records, review forms and/or itemized bills related to claims under the Program. The Program reserves the right to make benefit determinations based on these reviews and retract any reimbursement made based on falsified, misleading or incomplete information. The method of review and selection of cases will be determined by the Program.

B. Periodically the Program will perform retrospective audits of cases receiving inpatient or outpatient care, medical equipment supplier services or private duty nursing services. While the focus of each audit differs, the combined purposes of these audits are to confirm documented Medical Necessity of care received, relevance of pre-procedure diagnostic testing, if any, validation of the appropriate setting and/or use, quality of care and accuracy in coding and billing for services received. These reviews are conducted on Health Services Reviews, inpatient admissions or outpatient services (Retrospective Audits); outpatient surgical services received in ambulatory surgery or free standing ambulatory surgery centers (Ambulatory Surgery Audits); or Provider bills (Bill Audits).

XIII. Program Responsibilities

A. In making Medical Necessity and other coverage determinations, Anthem may give consideration, (to the extent that, and for as long as, Anthem deems appropriate) to nationally recognized, consensus-based and/or published medical literature and guidelines or to criteria that are based on these (or to any portion thereof). Examples of such guidelines and/or literature that may be utilized or considered, in whole or in part, include, without limitation, MCG™ (formerly Milliman Care Guidelines®). * Guidelines and/or literature (or any portion thereof) developed by other national or specialty organizations may also be utilized and/or given consideration (to the extent that, and for as long as, Anthem deems appropriate). All utilization review standards and criteria used by the Program are objective, clinically valid and compatible with established principles of health care. They are also sufficiently flexible to allow deviations from norms when justified on a case-by-case basis.

Information about any guidelines and/or literature currently being used by Anthem can be obtained by calling the Program.

*MCG™ (formerly Milliman Care Guidelines®) are a set of optimal clinical practice benchmarks for treating uncomplicated patients with common conditions. To obtain information about MCG™ or to obtain a copy of the Guidelines, visit its web site at http://www.careguidelines.com/ or call 1-888-464-4746. Due to licensing restrictions, the Program is unable to release entire volumes of the criteria. A copy of the specific section of the guideline used in making an adverse decision only may be obtained by contacting the Program.

B. Anthem's uses behavioral health Medical Necessity criteria for the purpose of determining benefit coverage and assisting behavioral health care professionals in understanding the basis of our level of care and continuation of care decisions. The criteria are primarily symptom and behavior-based, and were developed with input from behavioral healthcare practitioners throughout Virginia, including practitioners at academic institutions. The criteria are reviewed at least annually. The behavioral health medical directors lead this annual review process and are responsible for synthesizing input from the various sources, including relevant scientific literature and a consideration for other published criteria sets, and making appropriate revisions to the criteria. A number of persons, both internal and external to Anthem, are asked to review the criteria annually, including Anthem's behavioral health case management staff, behavioral health psychiatric consultants, and a sample of network Providers, including Providers specializing in treatment of children, adolescents, adults, substance abuse and dependency. The criteria are also reviewed annually by Anthem's advisory and quality committees. The latest version of the behavioral health Medical Necessity Criteria is made available to Providers and Covered Individuals at their request by calling Medical Management at the number listed in the Contact Information in Article I. and available at www.anthem.com/.
C. The Program arranges the services of physician consultants who are board certified specialists in all major specialty categories of health care on an "as needed" basis in conducting utilization review.

D. Review staff include licensed registered nurses, licensed clinical social workers, licensed professional counselors, or clinical nurse specialists with at least 3 years of clinical experience who conduct the first level review under the direction of the medical director. The medical director and physician consultants have current unrestricted licenses to practice medicine in the Commonwealth of Virginia. In addition, the physician staff members have unencumbered DEA licenses, evidence of Board certification and malpractice coverage if in active practice.

E. All Medical Necessity adverse decisions are made in the first instance by a medical director, physician consultant or for behavioral health, a doctoral-level clinical psychologists or certified addiction medicine specialist. The Program will make a good faith attempt to obtain information from the Provider prior to rendering an adverse decision. If an Admission Review or Health Services Review is questioned on the basis of Medical Necessity, at any time before the Program renders a decision, the treating Provider is entitled to review the issue of Medical Necessity with a physician consultant or peer of the Provider who represents the Program.

F. If the Program approves an Admission Review or Health Services Review as Medically Necessary, a length of stay or number of units with time frame will be certified. Instructions on the method for Continued Stay Review - whether onsite or telephonic – and for obtaining continued Health Services Review will be provided when the original request is certified. A certification number is generated on each initial review and is a reference number only and not a confirmation that the service is approved.

G. The Program will orally or electronically communicate any adverse decision to the treating Provider no later than two business days after receipt by the Program of all information necessary to complete the review. As used herein, an "adverse decision" means a decision by the Program that a health care service rendered or proposed to be rendered was or is not Medically Necessity or is Investigational. In the case of an adverse decision for continuing care, the Program will orally or electronically notify the treating Provider within 24 hours and follow up in writing within two business days of the decision*. The notification will include instructions on how the Provider, on behalf of the Covered Individual, may seek a reconsideration of the adverse decision, including the name, address, and telephone number of a contact at the Program. To request reconsideration, the Provider must submit it by telephone to the contact information listed in Article 1.

*The two-day timeframe does not apply to Medicare Advantage Covered Individuals. Federals Laws supersede state laws and accordingly CMS regulations allow 14 days to process service requests. The two-day timeframe also does not apply to Medicaid Covered Individuals and Dual Enrollees. Anthem will comply with required turnaround timeframes set forth in its contracts with DMAS for FAMIS and Medallion II as well as the three-way contract among Anthem, DMAS and CMS for the Commonwealth Coordinated Care Program (Duals Demonstration).

H. Anthem’s behavioral health department uses regionally-based provider profiling data that it generates to help determine the number of sessions or days that Anthem will initially certify for coverage when a Health Services Review is requested by mental health Providers. Specific information regarding this process is available by contacting the behavioral health medical director, manager behavioral health medical management, or provider network manager at 800-991-6045.

XIV. Reconsiderations of Adverse Determinations

• Providers shall have the right to a reconsideration of an Adverse Determination. Any such reconsideration shall be subject to the following rules/requirements:

• Reconsiderations may be requested via either telephone or facsimile by a Provider on behalf of a Covered Individual.

• Reconsiderations shall be performed by a physician or peer of the treating Provider other than the Provider that made the initial Adverse Determination.

• Anthem shall notify the Provider verbally at the time of the reconsideration determination, and in writing following the reconsideration determination of the adverse decision, including the criteria used and the clinical reason for the adverse decision. At the time of verbal notification of the reconsideration
determination, the Provider will be informed of the process for filling an appeal with the contact name, address, and telephone number.

- If the Provider requests that the adverse decision be reviewed by a peer of the Provider at any time during the reconsideration process, the request for reconsideration shall be vacated and considered an appeal. In such cases, the Covered Individual shall be notified that the reconsideration has been vacated and an appeal initiated, and that all documentation provided during the reconsideration process shall be converted to the appeal, and no additional action is required by the Provider.

- Any reconsideration shall be rendered and the decision provided to the Provider and the Covered Individual in writing within 10 working days of receipt of the request for reconsideration.

XV. Program Appeals

Providers may request an appeal on their own behalf or on a Covered Individual’s behalf. In order to request an appeal on a Covered Individual’s behalf, consent must be received from the Covered Individual. Appeal requests will be reviewed by the appropriate administrative and/or clinical specialists. The reviewers will not have been involved in the initial decision. They also will not be a subordinate of the person who made the initial decision. All relevant information submitted will be reviewed regardless of whether it was considered at the time the initial decision was made.

Providers can request appeals verbally or in writing within either 15 months of the date of service or 180 calendar days of the date notified of Anthem’s adverse decision, whichever is later, to the following address or telephone number:

Anthem Blue Cross and Blue Shield  
Attn: Grievances and Appeals  
P.O. Box 27401  
Richmond, VA 23279  
800-533-1120

Additional details about the appeals process are available at [http://www.anthem.com/](http://www.anthem.com/).
Attachment A

Patient Medical Record Documentation Guidelines

The medical record is a written account of all significant clinical information pertaining to a patient. It is a critical tool for continuity and coordination of patient care over time. Complete and thorough documentation of the patient's care, therefore, is synonymous with providing good care, since the conditions that encourage the first also contribute to the second. All medical record documentation must be maintained for 5 years for audit purposes. Standards for documentation are:

1. Each patient has an individual confidential medical record.
2. Each page contains patient ID.
3. Provider is identified on each entry.
4. Medical record is legible.
5. All entries are dated.
6. Medical records are readily accessible during normal office hours.
7. Specific allergies or drug reactions are documented prominently on the medical record.
8. For each patient there is documentation of the following:
   - Pertinent history and physical examination
   - Personal and biographical data
   - Current therapies
   - Signed physician orders for providers of private duty nursing and/or medical equipment
   - Additionally, the following documentation is included in the Attending Provider medical records for their patients:
     - Completed problem list inclusive of recurrent or chronic illnesses or diseases
     - Previous visit problems are addressed
     - Copies of written reports for diagnostic and therapeutic ancillary services utilized by the patient
     - Follow-up plan and/or return visit is documented for each encounter
     - Consultations with or referrals to other physicians and Providers, including information on any medical intervention as a result of these referrals
     - Consultant, lab and imaging studies reflect physician review
     - Periodic screening appropriate to patient age and conditions
     - Immunization record is complete (for pediatric Covered Individuals only - below age 16)
     - Health guidance/counseling is appropriately provided to Covered Individuals
9. For each visit, there is documentation of the following:
   - Reason for visit and chief complaint
   - Working diagnosis
   - Treatment plan, including prescribed medications
   - Patient education

Medical/Surgical Record Documentation Standards Inpatient and Outpatient Hospital

Sufficient documentation in the medical record is required to enable the Program review staff to determine Medical Necessity, quality of care, and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.
I. Documentation Criteria

A. All hospital services rendered must be appropriately documented in the Covered Individual's medical record. The medical record should be complete, legible and signed by the person providing the service. To be deemed complete, documentation of inpatient services must:

1. Describe the Covered Individual's clinical signs and symptoms (including specific examples) that necessitate admission including failed response to outpatient management.

2. Document an accurate and complete chronological picture of the Covered Individual's clinical course with accessibility to past and present diagnoses, and relevant health risk factors.

3. Support the intensity of the Covered Individual's evaluation and/or treatment, including Provider's thought processes and the complexity of medical decision-making.

4. Document the implementation of a treatment and discharge plan specifically designed for the Covered Individual, detailing frequency and type of treatment/medication and dosage; any referrals/consultations, and Covered Individual/family education follow up needs.

5. Document Covered Individual's progress, including response to treatment, change in treatment, change in diagnosis/condition, and Covered Individual's non-compliance (if relevant).

6. Document continuous skilled observation and intervention by trained personnel consultants.

7. Document reasons for and results of x-rays, lab tests, invasive procedures, and other ancillary services.

8. Document extenuating circumstances that necessitate short periods (less than 3 hours) of absence from the Hospital (i.e., court appearance, medical/surgical treatment).

9. All entries to the medical records should be dated and authenticated.

B. All professional provider services must adhere to the following guidelines:

1. Documentation in the medical record must verify each individual charge submitted to Anthem.

2. Documentation must specify date of service, time of service, type of service rendered, and the name and title of the health care professional who rendered the service. "Summary" notes, regardless of time periods summarized, will not be acceptable as verification of individual therapies or services provided.

3. The CPT/diagnosis codes reported on the health insurance claim form or billing statement should reflect the documentation in the medical record.

C. Discharge Planning should begin at the time of admission. The initial assessment and other intervention should be documented in the medical record.
Attachment B

Behavioral Health Documentation Standards

These documentation guidelines were developed by the Anthem's behavioral health specialists in conjunction with behavioral health professionals across the state, and may be used for the review of behavioral health services for applicable Health Benefit Plans. The determination of reimbursement requires adequate documentation of patient acuity and services provided. The Provider must maintain adequate and accurate clinical records.

Documentation must be legible and signed by the person providing the service. Legible documentation is required to substantiate reimbursement for services. Anthem reserves the right to retract or recover any payments made when there is absence of documentation, illegible documentation, or if documentation is insufficient to justify services billed, subject to all restrictions of applicable law.

Documentation should be complete, including positive as well as negative findings, and should be recorded in a timely manner. A progress note is generated and documented after each patient contact. The CPT and diagnosis codes reported on the health insurance claim form should reflect the documentation in the medical record. All medical record documentation must be maintained for 5 years for audit purposes.

Documentation must reflect who rendered what service, why, when and to whom.

Inpatient Documentation Guidelines

Sufficient documentation in the medical record is required to enable Utilization Review staff to determine Medical Necessity, quality of care and appropriateness of treatment and to verify services performed for the purpose of determining coverage and reimbursement.

Patients within a hospital setting must be under the medical supervision of a physician. The Attending Provider maintains responsibility for the total care of the patient. Although members of other disciplines write psychotherapy notes, the physician of record has the responsibility to document the Medical Necessity for the prescribed psychotherapy and the total treatment program.

Evaluations, assessments, and other services shall be made by credentialed and/or licensed professional staff according to hospital policy and professional standards.

I. Admission Note

A. Within 24 hours of a patient's admission, the Attending Provider and the nurse performing the initial assessments must personally document their findings in the medical record. Documentation must include the time the assessment was performed by the Attending Provider.

1. Documentation of the severity of the presenting problem must support the Medical Necessity of admission for inpatient hospitalization.
   a. The primary DSM IV Axis I and Axis II diagnosis must be documented by the physician and must be consistent with the presenting problem.

2. The patient's potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the following:
   a. presenting thoughts
   b. intent
   c. plan
   d. method

3. An initial diagnostic evaluation must be documented and include the following:
   a. date of exam
   b. presenting problem - supporting signs and symptoms
c. history of present illness  
d. previous treatment and outcome  
e. medical history, (including medications & allergies)  
f. social history/family history  
g. history of alcohol and drug use  
h. mental status exam  
i. diagnosis  

4. Initial treatment plan, including the goals for hospitalization, must be documented, providing the following information:  
   a. an estimated Length of Stay (LOS)  
   b. initial Discharge Plan  

5. Signatures and credentials are required documentation for the following:  
   a. Attending Provider  
   b. all licensed staff  

II. History And Physical  

Within 24 hours of admission, a history and physical (H&P) must be completed by a licensed physician and documented in the medical record. The H&P must evaluate the patient's physical and medical stability for treatment in an inpatient setting. An explanation of exceptions for any H&P component must be documented.  

A. H&P documentation is to include an evaluation of the following:  
   1. general appearance and nutritional status  
   2. skin and lymph  
   3. head and neck  
   4. eyes/vision  
   5. ears/hearing  
   6. nose  
   7. mouth and throat  
   8. chest and lungs  
   9. breast  
  10. heart  
  11. abdomen  
  12. genitalia  
  13. rectal  
  14. bones, joints and muscles  
  15. neurological; to include the following:  
     - motor  
     - sensory  
     - cranial nerves  
     - deep tendon reflexes  
     - strength  
     - cerebrum  
     - posture, gait
16. clinical impression, to include activity level

B. Signature and credentials of the physician are required.

C. Laboratory results must be documented in a timely manner.

III. Consultation Services

A. A consultation is the rendering of an expert opinion, in relation to the diagnosis or treatment of an illness or injury by a Provider other than the Attending Provider. The Provider must be qualified by training and experience to render an expert opinion in a given specialty.

B. The Attending Provider must order the consultation, and the Provider who renders it must include a written report in the medical record.

C. All consultations must be performed by the Provider billing for the service. Health Benefit Plans do not provide benefits for telephone consultations.

IV. Master Treatment Plan

A. A master treatment plan that addresses measurable goals and objectives relating to the presenting problems and defines realistic goals for discharge must be documented in the medical record within 3 days.

1. All therapies and disciplines involved must be addressed in the master treatment plan.

   a. The patient's strengths and weaknesses and the ability to reach realistic goals must also be documented.

   b. The master treatment plan must be current and updated at least every 7 days.

2. Discharge Planning must be documented in the master treatment plan.

3. Specific follow up plans for post discharge must be documented.

B. Psychological testing required for differential diagnosis and the development of a master treatment plan should be ordered within 3 days of admission and results documented in the medical record within 3 days of completed testing.

V. Progress Notes

A. Documentation in the patient's progress notes is required to address the patient's response to treatment.

1. After significant patient contact, all disciplines must record their assessment in the medical record. All entries must be dated and signed by each professional, noting their credentials.

   a. Interventions, goals of the master treatment plan and coordination of services must be substantiated.

   b. An explanation of positive or negative change in the patient's condition is required.

   c. Deterioration or complication following initiation or change of medication must be documented.

   d. Ongoing documentation of the patient's mental, functional and medical stress is required.

   e. Patient’s response to treatment must be documented

   f. A record of the use of any physical and/or chemical restraints or seclusion must be documented.

B. The medical record must reflect daily medical and nursing documentation of the severity of illness and intensity of services rendered, and a daily progress note documented by the psychiatrist.
VI. Psychotherapy

A. Documentation, written or dictated by the Provider, of psychotherapy sessions is required in the medical record to determine that the services were rendered and Medically Necessary.

B. The Provider must personally render all psychotherapy billed to the Anthem. It is recognized that there are useful milieu therapy groups run by other personnel, but these milieu therapy groups are included in the hospital charge and will not be reimbursed separately by the Anthem.

1. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.

2. For utilization review purposes and to qualify for reimbursement, one note for each psychotherapy session is required. The psychotherapy note must indicate the following information:

   a. date of service
   b. length of session
   c. statement of therapeutic focus, including the therapist's intervention(s)
   d. periodic reference to the patient's progress
   e. individuals present at the session
   f. a separate note must be written in the hospital record for each patient in group therapy, indicating the nature of the participation at each session

Outpatient Documentation Guidelines

A clinical record is required for all office psychotherapeutic services. Sufficient documentation is required to determine Medical Necessity, quality of care, appropriateness of treatment and to verify service performed for the purpose of determining coverage and reimbursement. The Provider must personally render all psychotherapy billed to the Anthem.

I. Clinical Evaluation

A. A clinical evaluation must be documented in the medical record:

   1. The presenting problem:
      a. history of present illness
      b. evidence of personal distress
      c. impairment of functioning
   2. Medical history including medication and allergy history; current medications prescribed with dosages noted
   3. Previous treatment and outcome
   4. Social history/family history
   5. History of alcohol and drug use
   6. Mental status exam
   7. Appropriate diagnosis
   8. The treatment plan with goals of treatment including the estimated number of treatment sessions to achieve goals
9. Signature and credentials of treating provider

II. Psychotherapy Notes

A. Patient interactions of less than 20 minutes in duration may be documented as medication evaluation, but may not be documented as psychotherapy sessions.

B. Clinical notes must be documented in a timely manner and include:

1. Patient's name
2. Date of service
3. Type and length of session
4. Individuals present at the session
5. Current symptoms
6. Current level of functioning
7. Focus of session, including the therapist's intervention(s)
8. Future directions including revisions in goals, if indicated
9. Next scheduled appointment
10. Summary of treatment outcome upon termination
11. A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
12. Signature and credentials of treating Provider after each session, including progress toward the individual's goals
Attachment C

Guidelines for Skilled Nursing Care in the Home Setting

Skilled nursing and skilled rehabilitation services are those services, furnished pursuant to physician orders, that:

- Require the skills of qualified technical or professional health personnel such as registered nurses, licensed practical (vocational) nurses, physical therapists, occupational therapists and speech pathologists or audiologists; and
- Due to the likelihood of change in an individual's condition, requires skilled nursing personnel to observe and assess the individual in order to identify and evaluate the need for possible modification of treatment or initiation of additional medical procedures, until the treatment regimen is essentially stabilized; and
- Must be provided directly by or under the general supervision of these skilled nursing or skilled rehabilitation personnel to assure the safety of the individual and to achieve the medically desired result; and
- Are not custodial in nature or solely for convenience. Custodial care is defined as:

  - Custodial care is that care which is primarily for the purpose of assisting the individual in the activities of daily living or in meeting personal rather than medical needs, which is not specific therapy for an illness or injury and is not skilled care.

  - Custodial care serves to assist an individual in the activities of daily living, such as assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that usually can be self-administered.

  - Custodial care essentially is personal care that does not require the continuing attention or supervision of trained, licensed medical or paramedical personnel.

  - Custodial care is maintenance care provided by family members, health aids or other unlicensed individuals after an acute medical event when an individual has reached the maximum level of physical or mental function.

  - In determining whether an individual is receiving custodial care, the factors considered are the level of care and medical supervision required and furnished. The decision is not based on diagnosis, type of condition, degree of functional limitation or rehabilitation potential.

Skilled nursing care in the home setting is provided on a part-time or intermittent basis as an alternative to an initial or repeated hospitalization. It requires an order from the treating physician with documentation of a specific plan of care, the skills of a professional health care provider such as a registered nurse or a licensed practical nurse, and is not custodial in nature.

These services are only covered when the patient's condition generally confines him/her to home except for brief absences.

An individual does not have to be bedridden, but leaving the home does require a considerable and taxing effort. The following are acceptable examples of situations that generally confine the patient to home. This list is not all-inclusive:

- CVA with severe hemiparesis.
- Severe COPD with SOB limiting ambulation.
- Unsteady gait - becomes SOB with ambulation of 10 feet or more. Requires walker and assistance of one person.
- Increased weakness, pain and stiffness due to post-op problems.

The following are examples of situations that generally confine the patient to home but which do not qualify the patient as being "homebound." This list is not all inclusive:

- Low endurance.
• Speech impairment.
• Hearing impairment.
• Inability to drive.

Appropriate documentation of the patient’s condition must be provided to help in determining whether a patient is generally confined to home.

Nursing assessment and care of a homebound patient is considered skilled when the complexity of the patient or medical treatment requires a licensed nurse to accurately assess and report findings to a physician for intervention.

Examples of skilled nursing care include the following:
• Parenteral medications and IV fluids received on a regular/continuous basis.
• Intravenous and enteral hyperalimentation.
• Extensive sterile dressing changes.
• Family instruction in assuming daily care for:
  • Enteral feedings - once feedings have been established and tolerated, nasogastric and gastrostomy feedings are no longer considered skilled.
  • Initial evaluation and teaching for home oxygen therapy.
  • Teaching for use of accucheck/ glucometer.
  • ET suctioning when suctioning is frequent.

Services NOT CONSIDERED to be examples of skilled nursing include but are not restricted to, the following:
• Checking of vital signs.
• Administration of routine oral or topical medications.
• Maintenance colostomy or ileostomy care.
• Routine catheter care.
• Use of local heat for symptomatic treatment.
• Non-sterile dressing changes.
• Prophylactic and palliative skin care.
• General methods of treating incontinence.
• General care of a plaster cast, braces or a prosthetic appliance.
• Assistance with ADL’s.
• Socio-economic factors do not determine whether care is skilled.
• Homemaker services
• Custodial Care
Credentialing

Credentialing and Recredentialing

Program Description

Definitions

AAPSF: Accreditation Association for Podiatric Surgical Facilities

AAAH: Accreditation Association for Ambulatory Health Care

AAAS: American Association for Accreditation of Ambulatory Surgery Facilities

ABC: American Board of Clinical Neuropsychology

ABMS: American Board of Medical Specialties

ABPN: American Board of Professional Neuropsychology

ABPP: American Board of Professional Psychology

ACHC: Accreditation Commission for Health Care

Administrative Action: A decision to terminate or reject a Practitioner, Provider or HDO from network participation for which Anthem’s basis for action is based on something other than the competence or professional conduct of a Provider, which affects or could adversely affect the health or welfare of a patient.

Adverse Administrative Action: A decision to terminate or reject a practitioner or HDO from network participation for other than a Professional Review Action.

Adverse Credentialing Decision: A decision to deny initial application or terminate a currently credentialed provider’s network participation when information reviewed during initial credentialing or re-credentialing indicates that credentialing or re-credentialing requirements are not met.

Anthem Enterprise: Anthem Health Plans of Virginia, Inc. d/b/a Anthem Blue Cross and Blue Shield and/or those companies that are under common control with Anthem Health Plans of Virginia, Inc.

Anthem Enterprise Medical Directors: Those VP Medical Directors with responsibility for the Medical Operations and Quality Management activities of the various companies within the Anthem Enterprise.

AOA: American Osteopathic Association

APA: American Psychological Association

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

CACREP: Council for Accreditation of Counseling and Related Educational Programs

CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

Certification: Board Certification as recognized by the American Board of Medical Specialties, the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, the College of Family Physicians of Canada, the American Board of Orthopedic and Primary Podiatric Medicine, the American Board of Podiatric Surgery or the American Board of Oral and Maxillofacial Surgery
**CHAMPUS**: The Civilian Health and Medical Program of the Uniformed Services (in the United States). CHAMPUS is a federally-funded health program that provides beneficiaries with medical care supplemental to that available in military and Public Health Service (PHS) facilities.

**CHAP**: Community Health Accreditation Program

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

**Clinical Peer**: A Practitioner, not otherwise involved in Anthem’s network management, who possesses the same state licensure as the Practitioner in question and whose practice is in the same or a similar Specialty.

**COAMFTE**: Committee on Accreditation for Marriage and Family Therapy Education

**Anthem Credentials Committee (CC)**: A local multi-disciplinary committee that has representation from appropriate types of practitioners and specialties.

**Credentialing staff**: Any associate in the Credentialing Department.

**CSWE**: Council on Social Work Education

**For Cause Termination**: A termination related (1) failure of a Provider to meet predetermined credentialing criteria related to professional conduct and competence; (2) quality of care; (3) patient safety; and (4) professional conduct or competence which affects of could adversely affect the health or welfare of a patient and/or that in the determination of the CC poses some potential risk to the health of the Anthem’s Covered Individuals.

**Formal Appeal**: The process by which Anthem’s adverse credentialing decision is challenged.

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

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

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

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

**IMQ**: Institute for Medical Quality

**Informal Review/Reconsideration**: A process through which an initial applicant or participating provider submits additional information to Anthem to correct or augment the information which resulted in an adverse administrative action or adverse credentialing decision. Reviewer(s) may be the same person(s) who were part of the original decision. As part of the Informal Review/Reconsideration, Anthem, at its discretion, may afford additional privileges to the practitioner or HDO, such as by way of example only, an opportunity to discuss the decision with an Anthem representative telephonically. In any event, an Informal Review/Reconsideration shall not include privileges equal to or greater than those offered in a Formal Appeal.

**Initial Applicant**: Any person or organization that provides health care services which has applied for participation with Anthem to provide health care services to Anthem’s Covered Individuals.

**Members**: Refers to Members or Covered Individuals.
**Mental Health Condition**: A condition that may impair the individual's judgment or emotional stability. Any disturbance of emotional equilibrium, as manifested in maladaptive behavior and impaired functioning caused by genetic, physical, chemical, biologic, psychological, or social and cultural factors.

**National Credentials Committee**: A committee composed of Anthem Enterprise Medical Directors, Medical Director of Medical Policy and Credentialing and chaired by the medical directors as designated by the VP responsible for Credentialing services. It is responsible for the development and maintenance of a consistent National Credentialing Policy. This committee shall establish policy governing all aspects of credentialing of network Practitioners and HDOs including, but not limited to scope, criteria, confidentiality, delegation, and appeals.

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

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

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

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

**Participating Provider**: Any person or organization that provides health care services, including Practitioners and facilities, and which has entered into an agreement with Anthem to provide health care services to Anthem Covered Individuals.

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

**Physical Condition or Impairment**: A physical disability or presence of an illness that may interfere with a Practitioner’s ability to practice to the fullest extent of their Specialty with or without accommodation or that could pose a risk of harm for patients.

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

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

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

**Provider**: Any person or institution that provides health care services, including Practitioners and facilities.

**Specialty**: Those fields of clinical practice recognized by Anthem’s Credentialing program.

**Substance Abuse Condition**: A condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on legal or illegal drugs which results in a chronic disorder affecting physical health and/or personal or social functioning.

**TJC**: The Joint Commission

**Policy 1 Credentialing Program Structure**

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

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

Policy 2 Credentialing Program Scope

Anthem credentialed the following types of contracted healthcare Practitioners when they are to be listed in Anthem’s provider directory: Medical Doctors, Doctors of Osteopathic Medicine, Doctors of Podiatry, Chiropractors, and Optometrists providing services covered under the medical benefits plan and Doctors of Dentistry providing services covered under the medical benefits plan including Oral Maxillofacial Surgeons, Psychologists with 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, Clinical nurse specialists with master’s level training, Psychiatric nurse practitioners who are nationally or state certified or state licensed, and other behavioral health care specialists who are licensed, certified or registered by the state to practice independently. Medical therapists, e.g., physical therapists, speech therapists, and occupational therapists, when an independent relationship exists between the Company and the provider, and the individual provider is listed individually in the Company’s network directory.

Practitioners with whom we have a contractual relationship do not require credentialing when the practitioner is not listed in network directory, and the individual: 1. practices exclusively within the inpatient or freestanding Professional setting, or, 2. provides care for Anthem’s Covered Individuals only as a result of them being directed to the hospital or other inpatient or free-standing Professional setting. Examples of this type of Practitioner include, but are not limited to: Pathologists, Radiologists, Anesthesiologists, Neonatologists, Emergency Room Physicians, Hospitalists, Pediatric Intensive Care Specialists and Other Intensive Care Specialists.

Anthem also credentials the following types of Healthcare Delivery Organizations (HDOs): Hospitals; Home Health Agencies; Skilled Nursing Facilities; (Nursing Homes); Free-Standing Surgical Centers; Lithotripsy Center treating kidney stones; Free-standing Cardiac Catheterization Labs, as well as Behavioral Health Facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Policy 3 Credentials Committee

All credentialing determinations are made by the Credentials Committee (CC), which reports to Anthem’s governing board. The CC is authorized, under authority from the governing body of Anthem and under the direction of the Chief Medical Officer, to evaluate all health care Practitioners and HDOs within the scope the Anthem’s Credentialing Program applying for participation or seeking continued participation in Anthem’s network. These applicants will be reviewed for issues related to their meeting Anthem’s established credentialing criteria. The CC may authorize the Chair or designated Anthem Medical Director to approve Practitioners meeting all predetermined criteria for credentialing or recredentialing. Upon individual review of Providers not meeting predetermined criteria, the CC may accept or deny those Practitioners or HDOs initially applying for participation, and to retain or terminate that Practitioner or HDOs requesting continued participation, in Anthem’s programs or networks.

The CC shall render a decision as follows pertaining to each application for initial or continued participation in one or more of Anthem’s programs or networks:

- Approve Participation
- Deny/Terminate Participation
- Pend/Table: additional information required or interview

CC determinations regarding practitioners terminated at recredentialing will be communicated in writing to the applicant or participating provider as outlined in Credentialing Policy #13. Other recredentialing determinations will be individually communicated in writing in the presence of and in accordance with specific regulatory, accreditation and contract requirements. The communication may occur electronically or via standard mail. This written communication to the applicant or participating provider will occur within sixty (60) calendar days of the CC decision and will include the determination and the rationale for it.
Practitioners requesting initial participation will be notified of the decision by appropriate Anthem personnel within ninety (90) days of receipt of a completed application or within 60 days of the CC decision, whichever is earlier. This notification may occur electronically or via standard mail.

Policy 4 Professional Competence and Conduct Criteria

Each health care Provider applying for initial credentialing or recredentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of Anthem’s programs or networks. Exceptions to these criteria must be reviewed and approved by Anthem’s Credentials Committee (CC).

Health Care Practitioners

1. Eligibility Criteria - all health care Practitioners within the scope of Anthem’s Credentialing Program applying for initial participation in Anthem’s programs or networks must meet the following criteria in order to be considered for participation:

   a. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Anthem’s Covered Individuals. Exception to this requirement may be made in the following instances:

      i. for those applicants not previously participating in Anthem’s networks whose licensure action was related to substance abuse, physical impairment or mental illness and who have demonstrated a minimum of two years of successful participation in a treatment and/or monitoring program with no evidence of recidivism, recurrence or relapse since the institution of the treatment/monitoring. Should this exception be entertained, Anthem may request specific documentation from the treating physician and/or program as it deems appropriate.

      ii. for applicants previously terminated from Anthem’s networks related to licensure action for substance abuse per Credentialing Policy #14, and who have demonstrated a minimum of one (1) year of successful participation in a treatment and/or monitoring program with no evidence of recidivism since that time. Should this exception be entertained, Anthem may request specific documentation from the treating physician and/or program as it deems appropriate.

      iii. In jurisdictions where the licensing entity issues licenses to new applicants at a frequency less than monthly, but does issue temporary licenses, Anthem may at its discretion, accept a temporary license. In instances where a temporary license is accepted, Anthem will also establish a timeframe in which a permanent license is required. Anthem will view any encumbrances, probation or other restrictive action taken against such an applicant as not meeting criteria.

      iv. In jurisdictions where the licensing entity issues a limited license with geographic limitations that are unrelated to professional conduct or competence (e.g., immigration status), Anthem may, at its discretion accept a limited license. Anthem will view any encumbrances, probation or other restrictive actions taken against such an applicant as not meeting criteria.

   b. Possess a current, valid, and unrestricted DEA and CDS registration for prescribing controlled substances if applicable to his/her Specialty in which he/she will treat Anthem’s Covered Individuals. The DEA/ CDS must be valid in the state(s) in which the practitioner will be seeing Anthem’s Covered Individuals. Practitioners who see Covered Individuals in more than one state must have a DEA/ CDS for each state. Practitioner types not requiring DEA:

      1. Chiropractors
      2. Optometrists
      3. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/Counselors, Nurse Practitioners working in behavioral health)
      4. Medical Genetics
      5. Nurse Practitioners
      6. Physician’s Assistants
      7. Medical Genetics
      8. Medical Therapists, e.g. physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (Policy 2)
9. Practitioners who deliver services in a telemedicine environment are required to have a DEA/CDS in their primary location, but are not required to hold additional DEA/CDS certificates to perform telemedicine services in additional locations where they are actively licensed to practice, unless DEA/CDS certification is required under federal or state law.

10. Radiologists practicing in an office setting.

i. initial applicants who have NO DEA/CDS certificate the applicant will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if all of the following are met:

   a. It can be verified that this application is pending

   b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA certificate is obtained,

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

   d. Anthem will verify the appropriate DEA/ CDS via standard sources

   e. The applicant agrees that failure to provide the appropriate DEA within a 90 day timeframe will result in termination from the network

ii. initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem’s Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if all the following criteria are met:

   a. It can be verified that this application is pending

   b. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA certificate is obtained,

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

   d. Anthem will verify the appropriate DEA/ CDS via standard sources

   e. The applicant agrees that failure to provide the appropriate DEA within a 90 day timeframe will result in termination from the network

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

Applicants for initial participation in Anthem’s programs or networks who do not meet the above criteria (a,b,c) will be notified of this failure to meet criteria and their applications will not proceed through the credentialing process. However, networks not serving Federal programs may review applicants debarred from Medicare, Medicaid and FEHBP on a case by case basis.

Applicants for continued participation in Anthem’s programs or networks that do not meet the above criteria will be considered on an individual basis by the CC.

2. Additional Eligibility Criteria for All Applicants (initial or re-credentialing) If an applicant for initial participation or continued participation in Anthem’s programs or networks does not meet one or more of the following criteria, the applicant’s history must not raise a reasonable suspicion of future substandard professional conduct and/or competence. The CC will consider the applicant’s history on an individual basis.

i. Application and supporting documentation must not contain any omissions or falsifications, (including any additional information requested by Anthem), or in the presence of omission or falsifications must not raise a reasonable suspicion of future substandard professional conduct and/or competence.
ii. Education, training and certification must meet criteria for the specialty in which the applicant will treat Anthem’s Covered Individuals including receipt of documentation of such education, training and certification from institutions acceptable to Anthem, or in the absence of such must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

iii. For MD’s and DO’s, current, in force board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical discipline for which they are applying is viewed as meeting all education, training and certification requirements. As alternatives, MD’s and DO’s meeting any one of the following criteria will be viewed as meeting this education, training and certification requirement:

(i) Previous board Certification (as defined by one of the following: ABMS, AOA, Royal College of Physicians and Surgeons of Canada or the College of Family Physicians of Canada) in the clinical Specialty or subspecialty for which they are applying which has now expired AND a minimum of 10 consecutive years of clinical practice. OR

(ii) Training which met the requirements in place at the time it was completed in the Specialty or subspecialty field prior to the availability of Board Certifications in that clinical Specialty or subspecialty. OR

(iii) 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 Professional in Anthem’s Network AND the applicant’s professional activities are spent at that institution at least 50% of the time.

Providers meeting one of these 3 alternative criteria (i, ii, iii) 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 Credentials Committee.

Anthem reserves the right, in its reasonable discretion, to waive the board Certification or alternative requirement when Anthem determines: 1) That there are extenuating or special circumstances that warrant the waiver of such requirement AND 2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

Individuals will be granted five years after completion of their residency or fellowship training program to meet the board Certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement unless the extenuating or special circumstances described in the above statement apply.

This board Certification requirement will not apply to MD’s and DO’s credentialed by the Anthem (or by an authorized delegated entity consistent with Anthem’s credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by Anthem of the need to become board certified. All Practitioners will continue to undergo oversight through the standard re-credentialing mechanism. Additionally, Anthem’s CC will assess unique situations where issues of limited access to care may dictate special consideration.

iv. For DPM’s (podiatrists) the applicant must be certified by either the American Board of Orthopedic and Primary Podiatric Medicine or the American Board of Podiatric Surgery. As an alternative, podiatrists who were previously board certified by either the American Board of Orthopedic and Primary Podiatric Medicine or the American Board of Podiatric Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this requirement. Podiatrists who meet the alternative requirement will not require additional review. Anthem reserves the right, in its reasonable discretion, to waive the board Certification requirement when Anthem determines: 1) That there are extenuating or special circumstances that warrant the waiver of such requirement AND 2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

Individuals will be granted five years after the completion of their residency to meet this requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement.
This board Certification requirement will not apply to podiatrists credentialed by Anthem (or by an authorized delegated entity consistent with Anthem’s credentialing policy) and in good standing in the network as of the effective date of this policy, unless they had been previously notified by Anthem of the need to become board certified. All Practitioners will continue to undergo oversight through the standard recredentialing mechanism. Additionally, the Anthem CC will assess unique situations where issues of limited access to care may dictate special consideration.

v. For Oral and Maxillofacial Surgeons, the applicant must be certified by the American Board of Oral and Maxillofacial Surgery. As an alternative, Oral and Maxillofacial Surgeons who were previously board certified by the American Board of Oral and Maxillofacial Surgery which has now expired AND who have had a minimum of 10 consecutive years of clinical practice will be viewed as meeting this requirement. Oral and Maxillofacial Surgeons who meet the alternative requirement will not require additional review. Anthem reserves the right, in its reasonable discretion, to waive the board Certification requirement when Anthem determines: 1) That there are extenuating or special circumstances that warrant the waiver of such requirement AND 2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or competence.

Individuals will be granted five years after completion of their residency or fellowship training program to meet the board Certification requirement. However, individuals no longer eligible for board Certification are not eligible for continued exception to this requirement.

This board Certification requirement will not apply to Oral and Maxillofacial Surgeons credentialed by Anthem (or by an authorized delegated entity consistent with Anthem’s credentialing policy) and in good standing in the network as of the effective date of this policy unless they had been previously notified by Anthem of the need to become board certified. All Practitioners will continue to undergo oversight through the standard recredentialing mechanism. Additionally, the Anthem CC will access unique situations where issues of limited access to care may dictate special consideration.

vi. For MD’s and DO’s, the applicant must have unrestricted hospital privileges at a TJC, NIAHO, or AOA 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. Some clinical disciplines may function exclusively in the outpatient setting, and Anthem’s CC may at its discretion deem hospital privileges not relevant to these specialties. (See Attachment A.) 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. Anthem CC will evaluate applications from Practitioners in such practices without regard to hospital privileges. The expectation of these physicians is that there exists an appropriate referral arrangement with a network physician providing inpatient care.

vii. Site visit and medical record review results, if applicable, must meet Anthem standards, or in the absence of meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

viii. Complaints from Covered Individuals and/or other Providers must be at levels deemed acceptable to Anthem, or if such complaints exist and/or exceed such levels must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

ix. Explanations for gaps in work history must be documented and meet Anthem standards, or in the presence of gaps that exceed such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence. A minimum of five years of work history will be obtained from Providers, and assessed for gaps. All gaps exceeding 6 months will require additional information. A verbal explanation will be accepted for gaps of 6 to 12 months. Gaps in excess of 12 months will require written explanation from the Provider.

x. History of professional liability suits, arbitrations or settlements must be within established Anthem standards, or in the presence of suits exceeding such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

xi. Performance indicators obtained during the credentialing or recredentialing process that meet Anthem standards, or if not meeting such standards must not raise a reasonable suspicion of future substandard professional conduct and/or competence.
xii. No physical or mental impairment, (including chemical dependency and substance abuse), that would affect the health care practitioner’s ability to practice within the scope of his or her license or pose a risk or imminent harm to Covered Individuals. In the presence of a history of physical or mental impairment, the nature of the impairment and other information obtained during the credentialing or recredentialing process must not raise a reasonable suspicion of future substandard professional conduct and/or competence.

xiii. No history of disciplinary actions or sanctions, against the applicant’s license, DEA and/or CDS registration, or Medicare, Medicaid or FEHBP participation, or actions or sanctions of such nature as to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process.

xiv. No history of disciplinary actions, sanctions, or revocations of privileges taken by hospitals and other healthcare facilities or entities, HMOs, PPOs, PHOs, etc. or, in the presence of such actions or sanctions, nothing in the nature of those to raise a reasonable suspicion of future substandard professional conduct and/or competence. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing or recredentialing process.

xv. No open indictments or convictions, or pleadings of guilty or no contest to, a felony, and any open indictments or convictions to any offense involving moral turpitude, or fraud, or any other similar offense, or in the presence of such history, nothing to raise a reasonable suspicion of future substandard professional conduct and/or competence.

xvi. No other significant information, such as information related to boundary issues or sexual impropriety or illegal drug use which might indicate a reasonable suspicion of future substandard professional conduct and/or competence.

HDO’s

1. Eligibility Criteria. All facilities within the scope of Anthem Credentialing program applying for initial participation in Anthem’s programs or networks must meet the following criteria in order to be considered for participation:
   a. possess a current, valid, unencumbered, unrestricted, and non-probationary professional license in the state(s) where it provides services to Anthem’s Covered Individuals, if such license is applicable;
   b. must not be currently debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP
   c. Must be in good standing with any other applicable state or federal regulatory body.

2. Additional Eligibility Criteria for Facilities If an applicant for initial participation or continued participation in Anthem’s programs or networks does not meet one or more of the following criteria, its history must not raise a reasonable suspicion of future substandard professional performance. The CC will consider the applicant’s history on an individual basis.
   a. Application and supporting documentation must not contain any material omissions or falsifications, including any additional information requested by Anthem.
   b. Complaints received from Covered Individuals and/or other Providers may be reviewed for compliance with Anthem standards.
   c. Performance indicators obtained during the credentialing or recredentialing process, if applicable, must meet Anthem standards.
   d. No indictments or convictions, or pleadings of guilty or no contest to, a felony or any offense involving fraud, criminal activities, abuse or neglect nor evidence of such conviction or pleadings by the principals of the Professional.
e. Any history of disciplinary actions, sanctions or investigations, including termination, warnings, or notices of potential poor performance related to the HDO’s license, accreditation or status with Medicare or Medicaid must be reviewed must not raise reasonable suspicion of future substandard performance or harm to Covered Individuals. Determination will be based upon the nature of the disciplinary action or sanction and other information obtained during the credentialing, recredentialing or sanction monitoring process.

f. Acceptable accreditation from a recognized entity exists or in the absence of this accreditation, a state or Medicare site survey must indicate that there are no deficiencies that are considered to adversely affect quality of care or patient safety. For non-accredited facilities the CMS or state site survey report may be reviewed by CC to make this determination.

Policy 4.1 Behavioral Health Practitioner (non-physicians) – Education Criteria

Anthem has identified and developed minimum acceptable criteria for all Practitioners who fall within the scope of its credentialing program. This policy specifically addresses only the education and training requirements of non-physician behavioral health Practitioners. All relevant requirements detailed in this policy including but not limited to: licensure, DEA (where applicable) work history (gaps and performance), disciplinary actions of any licensure agency, regulatory body, employer or managed care Anthem, criminal actions, impairments and/or substance abuse, site visits, liability experience, disclosure of adverse actions and Attestation during the application are applicable to these Practitioners as well.

These criteria outlined in this policy do not apply to those Providers credentialed by the Anthem (or an authorized delegated entity consistent with Anthem’s credentialing policy) and in good standing as of the effective date of this policy. These Practitioners will continue to undergo oversight through standard re-credentialing mechanisms.

Practitioners are reviewed for both initial credentialing and re-credentialing in accordance with the following minimum standards for participation. These Credentialing criteria pertain to all Practitioners of these Provider types. Practitioners will be credentialed according to the criteria applicable to their highest level of licensure. Practitioners failing to meet minimum criteria would be viewed as not eligible for participation. Anthem Credentials Committee (CC) may, however, assess unique access needs where issues of limited access to care may dictate special consideration. In these instances, the absence of any Certification or other requirement must not raise a reasonable suspicion of future substandard conduct and competence.

A. Eligibility Criteria – All Non-physician Behavioral Health Providers

All Practitioner types discussed in this policy requesting initial credentialing must meet the following criteria.

A minimum of two (2) years experience post-licensure in the field in which they are applying beyond their training program. Anthem reserves the right, in its reasonable discretion, to waive the two (2) years of experience post-licensure requirement when Anthem determines:

1) That there are extenuating or special circumstances that warrant the waiver of such requirement such as post-licensure practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two (2) years of post-licensure experience, AND

2) The Credentials Committee determines that there is no reasonable suspicion of future substandard professional conduct and/or compliance.

   - Additionally, Anthem’s CC will assess unique situations where issues of limited access to care may dictate special consideration.

B. Provider Type Eligibility Criteria - Education and Training

1. LICENSED CLINICAL SOCIAL WORKERS (LCSW)

Practitioner shall possess a Master’s or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education, CSWE. The program must have been accredited within 3 years of the time the Practitioner graduates. Full accreditation is required,
candidacy programs will not be considered. If Masters level degree does not meet criteria and provider obtained PhD training as a Clinical Psychologist, but is not licensed as such the Practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by 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 & FAMILY THERAPIST (MFT) OR OTHER MASTER LEVEL LICENSE TYPE

Practitioner shall possess a masters 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. Master or Doctoral Degrees in Divinity, Masters in Biblical Counseling, or other primarily theological field of study, do not meet criteria as a related field of study.

a. 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, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the practitioner graduates. If Masters level degree does not meet criteria and provider obtained PhD training as a clinical psychologist, but is not licensed as such the practitioner can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by CHEA. In addition, a Doctoral degree in one of the fields of study noted above from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

3. CLINICAL NURSE SPECIALIST

Practitioner shall possess 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 3 years of the time of the Practitioner's graduation.

a. 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 Board of Registered Nursing, if applicable.

b. 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

c. Valid, current, unrestricted Drug Enforcement Agency (DEA) Certificate, where applicable with appropriate supervision/consultation by a participating psychiatrists as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate State Controlled Substances Certificate if required.

4. CLINICAL PSYCHOLOGISTS

a. Criteria

In addition to a valid state clinical psychologist license, practitioner shall possess a Doctoral degree in clinical or counseling psychology or other applicable field of study from an institution that is accredited by the APA within 3 years of the time of the practitioner’s graduation. Education/Training considered as eligible for an exception is a provider 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.

b. Master level therapists in good standing on 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.

Policy 5 Initial Application

A. Health Care Practitioners.
Each Practitioner applying for initial participation in Anthem programs or networks must complete and submit Anthem's applicable credentialing application along with all required supporting documentation. The application process may occur either electronically or on paper.

1. The application materials sent by Anthem include, at a minimum the following:
   - cover letter or other explanatory information;
   - credentialing application; and
   - Attestation form

2. A Practitioner will be notified that he or she has the right to review information submitted to support their credentialing application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other Peer Review protected information. Providers are given written notification of these rights in the communication from Anthem which initiates the credentialing process.

3. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the Practitioner within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the Practitioner of their right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for the submission of this additional information and to whom the information should be sent. Depending upon the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation shall be sent thereafter. All communication on the issue(s) in question, including either copies of the correspondence or a detailed record of phone calls, will be clearly documented in the Practitioner's credentials file. The Provider will be given no less than 14 calendar days in which to provide additional information.

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

5. 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. These include: the letter which initiates the credentialing process, the provider web site or the provider manual. This notification includes the information needed to make this request. When such requests are received, providers will be notified whether the 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.

6. In completing the application, each applicant must disclose the existence of, and provide explanations for, the following:
   a. instances in which the applicant has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;
   b. Malpractice history, including pending malpractice suits and payments made by any malpractice carrier on the practitioner's behalf for any professional liability claim, suit, or judgment.
   c. involuntary termination by an employer or health care organization or resignation with knowledge of a pending investigation, or is aware that an investigation is pending that may lead to disciplinary action;
   d. revocation, suspension or limitation of privileges at a participating hospital, or resignation with knowledge of a pending investigation or any action which might lead to revocation, suspension or limitation of privileges;
   e. current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;
f. convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving or fraud, or any offense related to practice of healing arts, or is aware that an investigation is pending that may lead to such action.

g. instances in which the Practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHBP programs or is aware that an investigation is pending that may lead to such action;

h. revocations, suspensions or surrenders of the Practitioner’s Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, or is aware that an investigation is pending that may lead to disciplinary action if applicable;

i. physical or mental health reasons which would limit the Practitioner’s ability to provide services to a patient; and

j. additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application.

7. All Practitioners must sign and date an attestation statement that includes, but is not limited to:

a. reasons for any inability to perform the essential functions of the position, with or without accommodation;

b. lack of present illegal drug use;

c. history of licensing board action or felony convictions;

d. history of loss or limitation of privileges or disciplinary activity;

e. current malpractice insurance coverage; and

f. the correctness and completeness of the application.

g. Permission to release information as needed to complete the credentialing process

8. Each Practitioner must submit, along with the application, at a minimum the following:

a. curriculum vitae, resume or work history if work history is not included on the application;

B. Health Delivery Organizations (HDO).

1. Each HDO applying for initial participation in Anthem’s programs or networks must complete and submit Anthem’s applicable credentialing application along with all required supporting documentation.

2. The application materials sent by Anthem include, at a minimum the following:

   • cover letter or other explanatory information;
   • credentialing application;
   • Attestation form

3. In completing the application, each HDO must disclose the existence of, and provide explanations for, the following:

   a. instances in which the HDO has been the subject of any disciplinary review or action by any state licensing board or any federal agencies or is aware of a pending investigation that may lead to such action;

   b. instances in which the HDO’s malpractice insurance has been terminated, denied, suspended or limited or is aware of a pending investigation that may lead to such action;

   c. convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts during the past
five (5) years of an HDO principal officer or is aware of a pending investigation that may lead to such action;

d. instances in which the Professional has been sanctioned or debarred from Medicare, Medicaid or FEHBP programs or is aware of a pending investigation that may lead to such action;

e. additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application or additional issues regarding issues of professional competence and conduct.

4. All HDO applications must include a signed and dated attestation statement that includes, but is not limited to:

a. history of loss of license and felony convictions;

b. current malpractice insurance coverage; and

c. the correctness and completeness of the application.

5. Each HDO must submit, along with the application, at a minimum the following:

- Medicare Certification;
- Recognized accrediting organization Certification or Medicare or state site survey results

6. Upon request, HDO’s will be provided with the status of its credentialing application.

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

8. In the event that credentialing information cannot be verified or there is a discrepancy in the credentialing information obtained, the credentialing staff will contact the HDO to assist in obtaining the information or to provide detailed information regarding the issue in question. All documentation on the issue(s) in question, including a record of phone calls, will be included in the HDO's credentials file.

C. Non-discrimination Policy.

Anthem will not discriminate against any applicant for participation in its programs or networks on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem 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 which 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 and Providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Policy 6 Specialty Designations

A Provider’s requested Specialty is reviewed to assess if certain predetermined criteria as described in Policy 4 and as established by the National Credentials Committee are met. Only those Providers meeting these criteria are designated as that Specialty type.

A. Anthem’s recognizes all provider specialty designations recognized by the American Board of Medical Specialties (ABMS), the American Osteopathic Association (AOA) Bureau of Osteopathic Specialties, the Royal College of Physicians and Surgeons of Canada (RCPSC) or the College of Family Physicians of Canada (CFPC). Additionally, specialties not recognized by the ABMS AOA, RCPSC or CFPC but for which the Accreditation Council for Graduate Medical Education (ACGME) has designated accredited training programs will be eligible for recognition if deemed acceptable by the National Credentials Committee.
B. For provider types which are in the scope of the credentialing program, but for which the ABMS/AOA/RCPSC/CFPC/ACGME is not applicable, the National Credentials Committee will establish acceptable education and training requirements for recognition. Any specialty recognized by Anthem’s is eligible for use in directories, but determination of need for a specific eligible specialty designation is within the sole discretion of Anthem’s.

Specialties Recognized by National Credentialing Committee and Applicable Training Requirements
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Training Requirements</th>
</tr>
</thead>
</table>
| General Practice                    | 1. One year of training in the United States in a clinical discipline involving direct patient care in primary care, OB/Gyn or general surgery or any combination of these.  
   OR 2. A minimum of 10 years of practice experience in the community for which the provider is applying. All General Practice providers require Level II committee review and documentation of need. |
<p>| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Gynecology                          | Same training as obstetrics/gynecology (4 years accredited graduate medical education in an Ob/Gyn program with no less than 36 months of clinical Ob/Gyn). This designation is per the applying physician’s choice in place of, but in addition to, the designation of obstetrics/gynecology. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Internal Medicine and Pediatrics    | 1. Board Certified in both Internal Medicine AND Pediatrics OR 2. Successful completion of a dual residency program in internal medicine AND pediatrics with the stipulation that certification in both Internal Medicine and Pediatrics will be obtained within five years. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Addiction Medicine                  | 1. ABMS recognized pathway through psychiatry or HFAP certification, AND/OR 2. Current ASAM certification with ABMS/HFAP board certification in any specialty. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Sleep Medicine                      | Certification by a primary specialty board that is recognized by the ABMS or the HFAP and 1 full year of additional training in Sleep Medicine (PGY 3 or later via a Fellowship in Sleep Medicine or through an equivalent training period in an alternate ACGME approve program such as training in Sleep Medicine that takes place in a fellowship program in Pulmonary Medicine or Clinical Neurophysiology). |
| NCC Approved                        |                                                                                                                                                      |
| Pediatric Orthopedics               | Completion of a recognized ACGME training program in Pediatric Orthopedics OR Board Certified in Orthopedics and having privileges in orthopedics at a pediatric specialty hospital. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Pediatric Urology                   | Completion of a recognized ACGME training program in Pediatric Urology OR Board Certified in Urology and having urology privileges at a pediatric specialty hospital. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Pediatric Ophthalmology             | Board Certified in Ophthalmology and having privileges in ophthalmology at a pediatrics specialty hospital. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |
| Pediatric Neurosurgery              | Board Certified in Neurosurgery and having privileges in neurosurgery at a pediatrics specialty hospital. |
| NCC Approval Date: 12/21/05          |                                                                                                                                                      |</p>
<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Training Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatric Cardiac Surgery</td>
<td>Board Certified in Cardiovascular Surgery and having privileges in cardiac surgery at a pediatrics specialty hospital.</td>
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<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Pediatric Allergy &amp; Immunology</td>
<td>Board Certified in Allergy &amp; Immunology and two years training in Pediatrics.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
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</tr>
<tr>
<td>Glaucoma</td>
<td>Board Certified in Ophthalmology with one-year fellowship in Glaucoma at an institution with an ophthalmology residency program recognized by ACGME.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Retinal Disease</td>
<td>Board Certified in Ophthalmology with one-year fellowship in Retinal Disease at an institution with an ophthalmology residency program recognized by ACGME.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Adult Reconstructive Orthopedics</td>
<td>Board Certified in orthopedics and completion of a recognized ACGME in Adult Reconstructive Orthopedics.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Foot and Ankle Orthopedics</td>
<td>Board Certified in orthopedics and completion of a recognized ACGME in Foot and Ankle Orthopedics.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Orthopedic Trauma</td>
<td>Board Certified in orthopedics and completion of a recognized ACGME in Orthopedic Trauma.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Pain Medicine</td>
<td>Board Certification in Pain Medicine through ABMS or HFAP recognized process or Board Certification by the American Board of Pain Medicine</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>Completion of a recognized ACGME training program in Hematology and Oncology with board certification in both Hematology and Oncology or HFAP recognized process.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** 08/08/08 American Board of Urology approved certification for pediatric urology – First issued May 2008
Policy 7 Site Visits

A. Anthem will establish specific criteria and threshold standards related to sites where network practitioners see Anthem’s Covered Individuals. These standards will address at a minimum the following:

1. Physical Accessibility for individuals with special needs
2. Physical Appearance
3. Adequacy and appearance of waiting room space
4. Adequacy of examination room space
5. Availability of appointments
6. Adequacy of medical/treatment record keeping

B. Upon receipt of a Covered Individual complaint related to any of the items listed in 3A 1-4 above, Anthem will assess the complaint(s) using the criteria established in 3A. When the threshold is exceeded, an associate or agent of Anthem will perform a site visit within 60 days from the date the Covered Individual complaint was received.

PROCEDURES

A. Site Visit Evaluations

1) Site Evaluation Meeting Standards will be documented as such and practitioner notified. No further actions are required.

2) Site Evaluations NOT Meeting Threshold Criteria

   a. When a site visit fails to meet standards, the practitioner office will be notified of the details of the deficiencies and a specific, mutually agreeable, time frame for remediation will be established.

   b. Corrective action may consist of:
      i. Submission of a formal written corrective action plan, or
      ii. For isolated and easily corrected deficiencies, documentation of correction may be provided as evidence of remediation.

   c. Correction of any deficiencies noted on a site visit will be completed according to a mutually agreed upon timeframe.

   d. All site evaluations not meeting threshold will be reviewed at least every six months for progress towards goal.

   e. The follow up visit will specifically address the deficiencies noted on the earlier review.

   f. When the corrective actions are complete and the deficiencies corrected, a follow-up visit will be performed to document that the deficiencies have been corrected. No further action is required.

   g. When a practitioner fails to correct deficiencies, the issue will be referred to the appropriate quality review committee for additional review and action. If the quality review committee notes a site visit issue that it believes is of sufficient concern for consideration for termination of the practitioner(s), it will be referred to the Credentialing Committee.

   h. Covered Individual complaints regarding site visit issues related to office accessibility and appearance, or waiting room or exam room issues will be summarized every six months. This summary will be reviewed by appropriate quality review committee.

B. Recurrent Complaints About the Same Criteria or Office Site

1.) If the complaint threshold is met again for the same or different office site criteria, another office site visit is required. The same procedure listed under section “B. Site Visit Evaluation” would be followed.

Policy 8 Health Delivery Organizations, Exception Criteria for Non-Accredited HDO’s:
This policy defines the process and standards by which HDO’s within the scope of the ‘Anthem’s’ credentialing program are assessed for participation in Anthem networks. HDO’s include, but are not limited to: Acute Care Hospitals, Home Health Agencies, Skilled Nursing Facilities, Nursing Homes, Free-standing Surgical Centers, Lithotripsy Centers treating kidney stones, Free-standing Cardiac Catheterization Labs, and Behavioral Health Facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

HDO’s that participate in Anthem’s network and are within the scope of the credentialing program must meet appropriate standards of professional conduct and competence.

All HDO’s must have valid, in force accreditation by an Anthem recognized accreditation agency or meet exception criteria for non-accredited HDO’s.

Exception Criteria for Non-Accredited HDO’s Non-accredited HDO’s must:

1. have an access needs waiver submitted on their behalf; and
2. submit a copy of the Medicare or state agency survey report performed within the past 36 months to be retained in the provider’s file; and
3. have no deficiencies noted on Medicare or state oversight review which would adversely affect quality of care or patient safety; and
4. have the Medicare or state agency survey approved after individual review to validate compliance with Anthem standards by the Credentials Committee.

Note: Anthem itself does not perform site surveys.

Note: Non accredited facilities that participated in an Anthem network prior to the requirement for an access need do not require ongoing evidence of this access need.

The following tables describe the accreditation agencies Anthem recognizes as acceptable for the listed types of HDO’s. In each listing the acceptable standard is valid, in force accreditation. Detailed information regarding each entities accreditation types including what is acceptable to meet criteria is included in Attachment B. For facilities that require only state licensure, the license must be unencumbered.
## A. MEDICAL FACILITIES

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

## B. BEHAVIORAL HEALTH

<table>
<thead>
<tr>
<th>Professional Type (BEHAVIORAL HEALTH CARE)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Hospital - Psychiatric Disorders</td>
<td>TJC or NIAHO</td>
</tr>
<tr>
<td>Residential Care - Psychiatric Disorders</td>
<td>TJC, CARF, or NIAHO</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment - Psychiatric Disorders</td>
<td>TJC, CARF or NIAHO for programs associated with an acute care Professional or Residential Treatment Facilities.</td>
</tr>
<tr>
<td>Intensive Structured Outpatient Program - Psychiatric Disorders</td>
<td>TJC or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents CARF if program is a residential treatment center providing psychiatric services.</td>
</tr>
<tr>
<td>Acute Inpatient Hospital - Chemical Dependency/Detoxification and Rehabilitation</td>
<td>TJC or NIAHO</td>
</tr>
<tr>
<td>Acute Inpatient Hospital - Detoxification Only Facilities</td>
<td>TJC or NIAHO</td>
</tr>
<tr>
<td>Residential Care – Chemical Dependency</td>
<td>TJC, NIAHO or CARF</td>
</tr>
<tr>
<td>Partial Hospitalization/Day Treatment – Chemical Dependency</td>
<td>TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents. CHAMPUS or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.</td>
</tr>
<tr>
<td>Intensive Structured Outpatient Program – Chemical Dependency</td>
<td>TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents. CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents.</td>
</tr>
</tbody>
</table>

New HDO applicants will submit a standardized application to Anthem for review. Recredentialing of HDO’s occurs every 3 years unless otherwise required by regulatory or accrediting bodies. If unique network needs cannot be met by an accredited HDO, Anthem may review the most recent Medicare and/or state site review. These HDO’s will require individual review by the Credentials Committee. This may apply to either the credentialing or recredentialing process.
**Policy 9 Recredentialing**

All applicable Practitioners and HDOs in Anthem’s network are required to be recertified at least every three (3) years, unless otherwise required by contract or state regulations.

**Health Care Practitioners:**

If appropriate credentialing data to complete the recredentialing process is not available from the Universal Credentialing DataSource, a recredentialing packet or an electronic notification will be sent to the Practitioner at predetermined time prior to the recredentialing date. When the necessary information is available from the Universal Credentialing DataSource, this will be utilized. If after appropriate efforts to facilitate response (including at least one certified letter at some point prior to action by Anthem) the Practitioner does not respond in a timely manner the Practitioner may be administratively terminated.

Each Practitioner applying for continued participation in Anthem’s programs or networks must complete and submit Anthem’s applicable recredentialing application along with all required supporting documentation.

The application materials include, at a minimum, the following:

1. Explanatory Information
2. Application
3. Attestation form

The Practitioner will be notified of his/her right to review information submitted in support of the application. This right includes access to information obtained from any outside source with the exception of references, recommendations or other Peer Review protected information. Providers are provided with written notification of these rights by one of the following mechanisms: in the communication from Anthem which initiates the recredentialing process, on Anthem web site, or in the Provider manual. In the event that credentialing information obtained through other sources varies substantially from that provided by the Practitioner, Anthem credentialing personnel will notify the Practitioner of this discrepancy and of their right to correct errors or provide further information regarding the apparent discrepancy. This notification may occur in writing or verbally, as circumstances warrant, but will occur within 30 calendar days of the identification of the discrepancy. At the time of this communication the Practitioner will also be notified of the specific mechanism by which to correct errors or to provide detailed information as well as to who this information is to be submitted. Complete documentation of this notification including either copies of the correspondence or detailed information regarding phone calls will be maintained in the credentialing file. The Practitioner will be allowed no less than 14 calendar days to provide the requested information. All additional information received will be documented in the credentials file.

Upon request, Practitioners will be provided with the status of his or her recredentialing application. Written notification of this right is provided via the same mechanism as used by Practitioners. This notification includes the information needed to make this request. When such requests are received, Providers will be notified whether the 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 shall accept additional information from the Practitioner to correct incomplete, inaccurate, or conflicting credentialing information. The credentials committee will review this information and the rationale presented and determines if either a material omission has occurred or if other recredentialing criteria are met.

In completing the application, each Practitioner must disclose the existence of, and provide explanations for any activity since their last credentialing:

a. instances in which the Practitioner has been the subject of any disciplinary review or action by any state licensing board or is aware that an investigation is pending that may lead to disciplinary action;

b. malpractice history, including pending malpractice suits;
c. instances in which the Practitioner's malpractice insurance has been terminated, denied, suspended or limited or is aware that such action is pending;

d. payments made by any malpractice carrier on the Practitioner's behalf for any professional liability claim, suit or judgment(s);

e. involuntary termination by an employer or health care organization, or is aware of a pending investigation that may lead to such action;

f. revocation, suspension or limitation of privileges at a participating hospital, or is aware of a pending investigation that may lead to such action;

g. current illegal drug use or use of any chemical substances that would in any way impair or limit the ability to practice medicine and/or perform job functions with reasonable skill and safety;

h. convictions, whether as a result of a guilty plea, a plea of no contest or a verdict of guilty, of a felony, any offense involving fraud, or any offense related to practice of healing arts, or is aware of a pending investigation that may lead to such action;

i. instances in which the Practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHBP programs, or is aware of a pending investigation that may lead to such action;

j. revocations, suspensions (or revocations) of the Practitioner's Drug Enforcement Agency (DEA), or Controlled Dangerous Substances (CDS) certificates or licenses, if applicable, or is aware of a pending investigation that may lead to such action;

k. physical or mental health reasons which would limit the Practitioner's ability to provide services to a patient; and

l. additional information such as information regarding boundary issues or sexual misconduct or illegal drug use requested by Anthem to explain or provide details regarding responses obtained on the credentialing application.

All Practitioners must sign and date an Attestation statement. This Attestation may occur electronically or on paper and contains information that includes, but is not limited to:

a. Reasons for any inability to perform the essential functions of the position, with or without accommodation;

b. Lack of present illegal drug use

c. History of licensing board action or felony convictions

d. History of loss or limitation of privileges or disciplinary activity

e. Current malpractice insurance coverage

f. Attestation to the correctness and completeness of the application.

g. Consent to obtain information necessary for recredentialing

Each Practitioner must submit, along with the application, at a minimum the following:

- board Certification status information (if applicable)

At the minimum the following information will be verified:

a. A valid state license to practice, and information regarding any sanctions, probations or other actions taken against any state license

b. Copy of a valid DEA and CDS certificate or verification through the National Technical Services Database (if applicable)
c. Board Certification (only if the Practitioner's board Certification has expired or is new since the last credentialing. Not applicable for chiropractors.)

d. History of professional liability history

e. National Practitioner Data Bank Information

f. Hospital privileges or Attestation to participating hospitals (if applicable)

g. Office of the Inspector General activity

h. Medicare/Medicaid sanction activity

Health Delivery Organizations (HDOs):

Each HDO applying for continuing participation in Anthem's programs or networks will be reassessed on at least a three year cycle.

In performing recredentialing review all HDOs will be evaluated for the status of their licensure and accreditation. HDOs which have appropriate state licensure without sanction, probation or other adverse action and which have maintained accreditation by an agency recognized by Anthem will be viewed as meeting all criteria.

HDO's which are not accredited by an accrediting body (see Attachment B) will be evaluated at recredentialing with an assessment including the following elements:

a. State Department of Health Survey Results-a copy of the most recent state survey will be obtained and reviewed. HDOs with any deficiencies (even if these have been subjected to a corrective action plan which has been accepted by the State) will require specific Credentialing Committee review for issues of patient safety.

b. Center for Medicare Services (CMS) status. Those HDO types for which CMS assesses must be active CMS Providers. In addition, the CMS web site will be queried for applicable HDO types. In those instances where the State Department of Health Survey results reviewed in #1 above require individual committee review, the information from the CMS web site may also be provided to the Credentials Committee.

Upon request, HDOs will be provided with the status of its credentialing application.

Anthem may request and shall accept additional information from the HDO to correct incomplete, inaccurate or conflicting credentialing information. The credentials committee will review this information; the rationale presented, and determines if either a material omission has occurred or if other credentialing criteria are met.

c. Non-discrimination Policy

Anthem will not discriminate against any potential candidate on the basis of race, gender, color, religion, national origin, ancestry, sexual orientation, age, veteran, marital status, or health care Providers that serve high risk populations or those who specialize in the treatment of costly conditions. Other than gender and language capabilities which are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing or recredentialing process. Determinations as to which Practitioners and Providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing and recredentialing process.

Policy 10 Termination and Immediate Termination

A. A Practitioner's or HDO's participation in Anthem's programs or networks may be terminated for any lawful reason, including but not limited to failure to meet standard eligibility criteria due to a lapse in basic predetermined professional conduct and competence credentialing criteria, involving licensure (revocation, suspension or surrender), required medical staff Membership, privileges, Certification or accreditation. Additionally, a Practitioner's or HDO's participation in Anthem's programs or networks may be reassessed
when Anthem receives information relative to professional conduct and competence including but not limited to a history of professional disciplinary actions, malpractice history, sanctions under Medicare, Medicaid or FEHBP, unprofessional conduct, moral turpitude, criminal convictions, reportable malpractice actions, loss or surcharge of malpractice insurance, or other events which affects or could adversely affect the health or welfare of a patient reasonably calling into question the Practitioner’s or HDO’s ability, capacity or intent to deliver efficient, quality patient care.

B. Actions adverse to a Practitioner’s or HDO’s continued participation in Anthem’s programs or networks which are not based on concerns related to professional qualifications are not addressed in this policy, except to the extent that such practices may have been determined to be unprofessional conduct and/or competence by Anthem Credentials Committee (CC). Examples of such actions not addressed in this policy are those related to network over capacity, or unsatisfactory business or billing practices. These are viewed as Administrative Actions.

C. Additionally, whenever a Practitioner’s or HDO’s conduct requires that immediate action be taken as continued participation in Anthem’s programs or networks poses an imminent risk of harm to Anthem’s Covered Individuals or if the Practitioner’s license is suspended, probated or revoked, a process for Immediate Termination may be invoked.

PROCEDURES

A. Terminations:

If upon re-credentialing review or off-cycle review, the CC renders a decision of suspension or termination for cause, the Practitioner (or HDO) shall be so notified and advised of the right to appeal the determination. If the Practitioner (or HDO) invokes the right to appeal, the Provider (or HDO) shall be provided an appeal in accordance with procedure set forth in Credentialing Policy Appeals. If the Practitioner (or HDO) does not invoke the right to an appeal or the appeals process upholds the CC’s decision to suspend, terminate, the Practitioner (or HDO), along with appropriate internal Anthem departments, shall be notified of the effective date of the termination.

B. Immediate Termination:

1. Routine issues raised about a Practitioner’s (or HDO) professional conduct and/or competence shall be reviewed by the Chair of the CC and referred to the CC for review. However, when Anthem receives information that a Practitioner’s (or HDO’s) continued participation in Anthem’s programs or networks may pose some potential risk to the health or welfare of one or more of Anthem’s Covered Individuals or may potentially result in imminent danger to the health or welfare of one or more of Anthem’s Covered Individuals due to specific issues of professional conduct and competence, a process for Immediate Termination exists. In instances where such imminent risk or danger may be present, the Chair of the CC and/or Anthem Medical Director or designee, after consultation with legal counsel, may terminate the Practitioner’s participation in Anthem’s programs or networks, effective immediately and provide notice to the Practitioner (or HDO). The investigation in support of such Immediate Termination may occur in an expedited timeframe. The Practitioner (or HDO) shall be sent a written statement, by certified mail, of this decision.

2. When the process for Immediate Termination is invoked, the action will be reported and reviewed and the next scheduled meeting of the Credentials Committee.

3. The Practitioner (or HDO) may have the right to appeal, but participation may not be reinstated during the appeals process. If a decision to immediately terminate a Practitioner (or HDO) is overturned on review or appeal, the Practitioner (or HDO) shall be reinstated, and will not lose any of the protections to which Practitioner (or HDO) had been entitled before the Immediate Termination. These include the exemption from criteria such as Certification or accreditation based on their prior participation.

C. Reporting:

Anthem shall comply with the reporting requirements of state licensing agencies and the National Practitioner Data Bank, the Federal Healthcare Quality Improvement Act (Title IV of Public Law 99-660) regarding adverse credentialing and Peer Review actions, and/or other organizations as required by law.
Policy 11 Report of Adverse Actions

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 in this Policy for reporting reportable adverse actions conflict with the process set forth in the current National Practitioner Data Bank (NPDB) Guidebook and the Healthcare Integrity and Protection Data Bank (HiPDB) Guidebook, the process set forth in the NPDB Guidebook and the HiPDB Guidebook will govern.

PROCEDURES

A. Reporting

1. When a Professional Review Action is taken by Anthem with respect to a professional Provider's participation in one or more Anthem networks, Anthem may have an obligation to report such to the NPDB and/or HIPDB. Once Anthem receives a verification of the NPDB report, the verification report will be sent to the state licensing board.

   a. NPDB. Professional Review Actions of individual physicians and dentists shall be reported in writing to the applicable state licensing board, following that state's requirements for filing a written report. (Institutional Providers are not subject to this reporting requirement). Anthem will also report such occurrences electronically to the NPDB. The report shall be filed with the state licensing board and NPDB no later than 15 days after the actual effective date of the Provider's termination.

   b. HIPDB. All Professional Review Actions for all Provider types shall be reported to the HIPDB. The report shall be filed with HIPDB no later than 30 days from the actual effective date of the Provider's termination.

   c. Notwithstanding the foregoing, Anthem may report the matter to other appropriate governmental or private organizations, provided such reporting is approved in advance by the Legal Department in conjunction with consultation with the Special Investigations Unit.

2. If Anthem, in its discretion, accepts a Provider's voluntary resignation or without cause termination in lieu of Anthem's termination of the Provider for any reason that would otherwise lead to a Professional Review Action then Anthem may have a reporting obligation despite the fact that a Formal Appeal was not offered. Thus, the Legal Department must be consulted prior to any without cause terminations or prior to accepting any voluntary resignations for reasons other than retirement, the Provider moving from the area, or other reason that is not truly for cause.

3. Any report made under this Policy and Procedure shall only include the minimum necessary information to fulfill our reporting obligation.

4. Anthem's failure to report as required under applicable laws can result in fines and Civil Monetary Penalties against Anthem.

5. Anthem shall protect from disclosure any information that it reports to or receives in a report from NPDB, HIPDB, or state licensing board.

6. All Professional Review Actions must be reviewed by the Legal Department in advance of any report to the state licensing board, NPDB or HIPDB.

7. The Credentialing Manager/Director is the Anthem authorized representative for initiating the reporting of adverse actions. The Anthem's credentialing staff will compile the necessary information following Anthem Credentials Committee Action and submit the appropriate forms for review by the Anthem's legal counsel. After review and confirmation by legal counsel, the Credentialing Manager/Director will notify via IQRS the state licensing agency, NPDB and HiPDB as required by law. The Chair of the CC will have final approval and signature on all Adverse Action Reports when required or appropriate. All reports made to NPDB and/or HiPBD shall be in accordance with the current guidelines established for such databank.
B. Reporting Requirements to the National Practitioner Data Bank/Healthcare Integrity and Protection Data Bank:

All Physicians and Dentists are subject to reporting of adverse actions. In addition, other allied health professionals may be subject to reporting under certain circumstances. Full description regarding requirements for allied health professionals is available on the internet at [http://www.npdb-hipdb.com/](http://www.npdb-hipdb.com/).

All reports to the NPDB/HIPDB must be submitted electronically. Reports will be submitted via the Internet using the Integrated Querying and Reporting Service (IQRS) at www.npdb-hipdb.com, or on diskette in a format specified by the NPDB/HIPDB. Details on the format specified for submissions may be obtained by calling the NPDB/HIPDB Help Line at 1-800-767-6732.

Anthem will notify the State Licensing Agency on the Adverse Action Report form (available electronically to NPDB authorized entities) within 15 days of the date of any final reportable action taken against a Practitioner for a period longer than 30 days that adversely affects the Practitioner’s participation in the Anthem’s programs or networks, any voluntary surrender of participation or privileges by a Practitioner under investigation by the Credentials committee for possible incompetence or improper professional conduct, or voluntary surrender of participation or privileges by the Practitioner in lieu of such investigation.

Prior to mailing the Adverse Action Report to the applicable State Agency, the form must, at a minimum be, reviewed by the Anthem’s legal counsel and Medical Director. Once the form has been reviewed by the Anthem’s legal counsel, Medical Director and any other appropriate parties, the Anthem’s credentialing staff will mail the form via Certified/Return Receipt Requested and stamped “Confidential”.

C. Reporting Errors, Omissions, and Revisions

1. Any errors/omissions to an Adverse Action Report found after a report has been filed with the State Agency and/or the NPDB/HIPDB must be sent to the State Agency and/or NPDB/HIPDB as soon as possible to prevent the disclosure of any inaccurate or incomplete information.

2. If errors or omissions are found after information has been reported, corrections must be submitted via IQRS. When the NPDB/HIPDB processes a correction submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a correction is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Report Revised, Voided, or Status Changed document is mailed to the subject of the report and all queries who received the previous version of the report within the past 3 years. Anthem and the Practitioner should review the information to ensure that it is correct.

3. A “Revision to Action” is a new action that is related to and modifies a previously submitted adverse action. If adverse action information was reported, then any revisions to that action must also be reported. When the HIPBD processes a Revision to Action submitted via the IQRS, a Report Verification document is stored for the reporting entity to retrieve through the IQRS. When a Revision to Action is submitted on diskette, the Report Verification document is sent to the reporting entity via the U.S. Postal Service. Additionally, a Notification of a Report in the NPDB/HIPDB is mailed to the subject of the report. Anthem and the Practitioner should review the information to ensure that it is correct. Revisions are subject to the same time constraints and procedures as the initial action. Revisions include reversal of a Professional Review Action or reinstatement of the Practitioner’s participation in Anthem’s programs or networks.

D. NPDB/HIPDB Reporting Questions:

Then questions arise regarding querying or reporting requirements, the Compliance Staff will call the NPDB/HIPDB Hotline for assistance at 800-767-6732. The calls will be documented with date and time,
person spoken to, and a brief narrative of the call. Assistance from the Anthem’s legal counsel will also be sought as necessary.

**Policy 12 Ongoing Sanction Monitoring**

Credentialing associates perform 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 30 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
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments.
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and non clinical nature, reports of adverse clinical events and outcomes, and satisfaction data, as available)
7. Other internal Anthem Departments
8. Any other verified information received from appropriate sources

When a participating Practitioner or HDO has been identified by these sources, credentialing criteria will be used to assess the appropriate response. These responses include, but not limited to: review by the Chair of the Anthem’s Credentials Committee (CC), review by the Anthem’s Medical Director, referral to the CC, or termination.

**PROCEDURES**

Credentialing staff will review information from the previously referenced external sources as well as periodic information submitted by internal departments to the credentialing department.

**A. Sanction Monitoring**

If information regarding a participating Practitioner or HDO is identified in an external source, the Practitioner's or HDO's applicable credentialing information will be forwarded to the Chair of the CC, or Anthem Medical Director or designee to determine the urgency of the need for response. If urgent action is required, the Practitioner or HDO may be subject to the Immediate Termination process. If urgent action is not required, the Practitioner's or HDO's file will be prepared for the next scheduled CC meeting. Anthem may request additional documentation from the reporting agency and/or the Provider at any point in the monitoring process. The issues will be reviewed in light of predetermined criteria, either credentialing eligibility standards, or performance monitoring standards.

**B. Performance Monitoring**

Anthem’s credentialing department will incorporate internal information regarding a Practitioner's performance in the ongoing monitoring process whenever such information is available.

1. Sources for this include, but are not limited to
   a. Quality Improvement activities,
   b. Quality Reviews of complaints from any credible source,
   c. Individual case review performed by internal quality departments,
   d. Adverse events or outcomes review
   e. Medical records reviews
   f. Covered Individual’s complaints and grievances.
2. For recurrent information types, the applicable Anthem’s quality review committee may establish specific thresholds that may indicate problems with professional conduct and competence.

3. All referrals from internal sources will have been reviewed by an appropriate internal Anthem review committee prior to their submission to the credentialing department. These will be referred to credentialing when the results of that internal review are such that consideration of formal credentialing action is warranted.

4. Internal sources may be queried periodically or internal departments may provide reports on a periodic basis to detect any trends, problems and issues regarding individual Practitioners or HDOs.

5. If the credentialing staff determines that the Practitioner or HDO has exceeded predetermined thresholds as described above, the Practitioner's or HDO's credentialing information will be reviewed with the Credentialing Manager and the Manager of the department making the report, or his or her designee. This review should include all information from the reporting department, any corrective actions, plans, and correspondence sent to the Practitioner or HDO from the reporting department to help ensure that the appropriate internal Anthem quality review committee has occurred and that the referral to credentialing is appropriate.

6. All the information obtained pursuant to this review will become part of the Practitioner’s or HDO's credentialing information and be forwarded for review by the Chair of the CC or designee. The Chair of the CC or designee will review the file to determine if the issues of professional competence or conduct are of an urgent nature to warrant Immediate Termination. If the issues do not warrant Immediate Termination, the Provider is referred to the CC.

Policy 13 Informal Review/Reconsideration and Formal Appeal of Adverse Credentialing Decisions

Anthem has established policies for credentialing initial applicants and monitoring and re-credentialing providers who seek continued participation in one or more of Anthem's networks. When information reviewed during this activity indicates that credentialing or re-credentialing requirements are not met, Anthem may deny initial application or terminate a currently credentialled provider's network participation. Depending on the circumstances of the refusal of initial application or termination of network participation, a participating provider may have the ability to pursue Informal Review/Reconsideration and/or Formal Hearing.

Initial applicants denied network participation may submit additional information as an Informal Review/Reconsideration. In those limited instances when the refusal of network participation results in a unique NPDB report by Anthem, the initial applicant may also pursue a Formal Appeal.

Participating providers whose network participation has been terminated for professional competence and conduct reasons by Anthem’s Credentialing Committee (CC), including immediate termination imposed due to Anthem’s determination that the practitioner’s continued participation poses an imminent risk of harm to the Anthem’s Covered Individuals, or when termination requires a unique report to the National Practitioner Data Bank (NPDB) may request an Informal Review/Reconsideration as well as pursue a Formal Appeal.

Participating providers whose network participation has been terminated due to Administrative Action or for professional conduct and competence reasons which do not require CC review (e.g., failure to obtain board certification, lack of hospital privileges) are eligible for Informal Review/Reconsideration but not eligible for Formal Appeal.

Participating providers whose network participation has been terminated due to the practitioner’s suspension or loss of licensure or due to criminal conviction are not eligible for Informal Review/Reconsideration or Formal Appeal.

PROCEDURES

A. Informal Review/Reconsideration.

1. Notice.
   a. Terminations of Participating providers.
When participation was terminated for professional competence and conduct reasons by Anthem’s CC or when termination requires a report to the NPDB, the credentialing staff will notify the provider via certified letter of the decision. The notice will contain:

i. the reason for the decision, and

ii. a statement that the provider has the opportunity for an Informal Review/reconsideration of the decision and that the provider has the right to submit additional information to Anthem to correct any errors in the factual information which led to the determination or provide other relevant information, and

iii. a summary description of the Informal Review/Reconsideration, and

iv. a statement that the provider has the right to waive the Informal Review and proceed directly to a Formal Hearing, and the consequences of waiving this right, and

v. a statement that the provider must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the credentialing department for a review of the decision, along with any additional information the provider wishes to be considered.

b. Denial of Initial Applicants.

When initial application is rejected by Anthem’s CC, the credentialing staff will notify the provider via certified letter of the decision. The letter will contain: the reason for the decision, a statement that the provider has the opportunity for an Informal Review/reconsideration of the decision and that the provider has the right to submit additional information to Anthem to correct any errors in the factual information which led to the determination or provide other relevant information, and a statement that the provider must submit, within the thirty (30) calendar day period immediately following the date of receipt of the letter (unless otherwise required by state regulation), a written request to the Credentialing Department for a review of the decision, along with any additional information the provider wishes to be considered.

Note: A request for an Informal Review/Reconsideration shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract.

2. Request for Reconsideration/Informal Review.

The provider may request a Reconsideration/Informal Review of a CC decision which is adverse to the provider’s network participation. This request must be in writing, sent via certified mail, and received by the credentialing department within thirty (30) calendar days (unless otherwise required by state regulation) of the date the provider received the letter from Anthem with its determination based on the committee results.


Additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/ Reconsideration along with the information used as the basis for the initial decision and forwarded to the CC for review at its next meeting. The provider under review may provide written information, but is not present during the CC meeting. For initial determinations, if the information submitted by the provider contains no new objective information, it may be presented in summary form.

4. Reconsideration/Informal Review.

The CC will review the additional information submitted by the provider along with the information obtained during the initial credentialing or re-credentialing process and the basis for its initial decision at a regularly scheduled CC meeting or at a special review meeting. The CC will then determine whether to uphold or overturn its initial decision.

5. Review Results.
The CC decision on the Reconsideration/Informal Review is reported to the credentialing department within five (5) business days of its decision. The credentialing staff then notifies the provider via certified mail within fourteen (14) calendar days of the decision. For providers requesting Reconsideration/Informal Review of a denial for initial participation in Anthem’s networks this is the final level of review, unless Anthem’s action is to be reported to the NPDB. Whenever an action is to be reported to the NPDB, the provider will be afforded the right to a Formal Appeal.


The notice of the outcome of the Reconsideration/Informal Review will contain:

   a. The reason for the decision;
   b. Where a provider is eligible for Formal Appeal, a statement that:
      i. The provider has the opportunity to submit additional information to the Anthem for appeal of the decision; and
      ii. A summary description of the appeal process described below.
   c. A statement that, if the provider desires an appeal, the provider must submit, within the thirty (30)-calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
      i. A written request to the credentialing department for an appeal of the decision; and
      ii. Any additional information the provider wishes to be considered.

When the provider is eligible for and requests a Formal Appeal, the effective date of the termination, unless otherwise required by state law or regulation or by contract, will be delayed until the date the Appeal hearing decision is rendered or a decision not to continue pursuing a hearing is communicated by the provider to credentialing staff.

B. Formal Appeal

1. Formal Appeal Hearing, Upon Request.

   A provider who has been terminated from the network or whose denial for initial participation will be reported to the NPDB may request a formal appeal hearing. This request must be in writing and received via certified mail within the thirty calendar (30) day period immediately following the date of the provider’s receipt of the notice from Anthem.

   If a provider timely requests a hearing, the following procedures will be followed:

   a. The credentialing staff will notify Anthem’s Medical Director, and Anthem’s legal counsel, of the provider’s request for a hearing.
   b. Hearing Panel. Anthem’s Medical Director or designee will select the members of the hearing panel. The hearing panel will be comprised as set forth below unless other panel criteria may be required under applicable law.
      i. At least three (3) practitioners not involved in the original decision; and
      ii. The hearing panel will be chaired by the Anthem’s Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel; and
      iii. No person who is in direct economic competition with the provider may serve on the hearing panel; and
      iv. Only hearing panel members not involved in the original decision may vote.
      v. At least one of the hearing panel members will be a clinical peer.
c. Additional hearing panel criteria for physicians that participate in Medicare Advantage (MA) products:
   i. The majority (e.g. two out of a typical 3 member panel) of the hearing panel members will be clinical peers.

d. Hearing Notice. Within thirty (30) business days of receipt by Anthem of a provider’s request for a Formal Appeal, the credentialing staff will send a certified letter notifying the provider of the date, time, and place of the formal hearing. It will advise the provider that he/she may appear in person or by telephone. This letter will also summarize the hearing procedures and notify the provider that he or she may appear with a legal representative or other designee before the hearing panel, and that such provider has the right to:
   i. have a record made of the proceedings, copies of which may be obtained by the provider upon payment of any reasonable charges associated with the preparation thereof;
   ii. call, examine, and cross-examine witnesses;
   iii. present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
   iv. be represented by an attorney or another person of their choice,
   v. submit a written statement at the close of the hearing, and
   vi. receive upon completion of the hearing, the written decision of the panel, including a statement of the basis for the decision.

Such notice will also state that the provider will forfeit his or her right to a hearing if the provider fails to attend the hearing (either in person or by telephone) without good cause.

e. In advance of the hearing, the Credentialing staff will give each hearing panel member a copy of the denial and/or termination letter originally sent to the applicable provider. The panel members may also be provided with any other material deemed relevant by Anthem at or in advance of the hearing.

f. Hearing Date. The hearing date will be not less than thirty (30) nor more than sixty (60) calendar days after the date of the notice given to the provider of the date, time, and place of the formal hearing or as otherwise agreed to by Anthem and the affected provider.

2. Hearing Procedures.

The chairperson of the hearing panel, who is the Medical Director or his/her designee, will open the hearing by stating the purpose and protocol of the hearing.

a. During the hearing, the provider will have the ability to exercise any or all of the rights set forth in Section 1(d), Hearing Notice above.

b. A representative of Anthem will present the reasons for the decision to reject or terminate the provider.

c. The provider will present reasons why his or her participation should not be rejected or terminated.

d. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.

e. The maximum duration of the hearing will be two hours unless the chairperson of the hearing panel, in his or her discretion, determines that the hearing cannot reasonably be concluded in that time period.

f. The hearing panel will meet privately after the hearing to reach a decision. Each voting member of the hearing panel will have one equal vote. The hearing panel will have the authority to uphold,
reject, or modify the original decision based on a preponderance of evidence presented at the hearing. The decision must be reached by a majority vote.

g. The hearing panel will prepare a written decision, including the rationale, for its decision.

3. Review Results and Notice

Anthem’s Medical Director shall report the decision of the hearing panel to the credentialing department within five (5) business days of the date of the hearing. The credentialing staff shall notify the provider via certified mail, return receipt requested, within ten (10) calendar days of receiving notification from the Medical Director of the hearing panel’s decision and rationale.

C. Reporting Final Adverse Actions.

Anthem will report any final adverse actions in accordance with Credentialing Policy.

For those practitioners and providers participating in a Medicare Advantage Network, the Formal Hearing will follow this rule:

   a. Formal Hearing, Upon Request.
      i. Hearing Panel.

      When the provider requesting the Formal Hearing is a physician in the Medicare Advantage program, the Anthem Medical Director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three (3) practitioners not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person who is in direct economic competition with the practitioner may serve on the hearing panel. Two of the hearing panel members will be clinical peers. The hearing panel will be chaired by the Anthem’s Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel.

Policy 14 Reapplication after Termination or Denial

The time line that permits Practitioners or HDOs the opportunity to reapply for participation in one or more of the Anthem’s programs or networks, after a Professional Review Action has been taken by the Anthem Credentials Committee (CC) to deny or terminate the Practitioner’s or HDO’s participation varies depending upon the issues involved and is set forth herein. This policy is not intended to define reapplication time frames for denials or terminations taken for administrative and/or business reasons.

Nothing in this Policy requires Anthem to automatically accept previously denied or terminated Practitioners. Practitioners and HDOs reapplying for participation or requesting reinstatement in one or more of Anthem’s programs or networks, must complete an application, meet current participation criteria, and be approved by the CC.

PROVIDER PROCEDURES

A. Failed site visit (where applicable):
   A Practitioner (or HDO) may reapply once the location undergoes a site visit by Anthem, or its designee, that meets Anthem’s standards.

B. Physical/mental impairment:
   A Practitioner may reapply upon Anthem’s receipt of documentation from the Practitioner’s treating physician that the Practitioner is physically and mentally capable to perform within the scope of practice for which application is made and that the Practitioner’s status does not suggest future probable substandard professional conduct and competence.

C. Suspension of hospital privileges:
A Practitioner may reapply upon Anthem’s receipt of documentation from the hospital or other applicable authority that the action has been cleared OR may reapply after a period of one (1) year after the final action and the Practitioner has privileges at an appropriate Professional.

D. Chemical/Substance Abuse:
Reapplication may occur when either one of the following are met whichever occurs first:

1. If this licensing agency has taken action related to substance abuse, a Practitioner may reapply after a period of one year of active participation in a treatment program, with receipt of a statement or other legally required documentation from the Practitioner’s supervising physician and any applicable State required program for impaired Practitioners. This statement must indicate that the Practitioner is in a successful maintenance program with no evidence of recidivism and the Practitioner’s status does not suggest future probable substandard professional conduct and competence. OR

2. A Practitioner may reapply upon removal of all licensure encumbrances, have been removed.

E. Falsification on application or supporting documentation:
A Practitioner or HDO may reapply one (1) year after the occurrence.

F. Restricted DEA and/or State Certification:
A Practitioner or HDO may reapply upon Anthem’s receipt of documentation from the applicable authority that the restrictions have been lifted.

G. License Sanctions:
A Practitioner may reapply upon Anthem’s receipt of documentation from the applicable authority that the license is no longer sanctioned/encumbered.

H. Other Quality Issues:
A Practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.

I. Malpractice History:
A Practitioner or HDO may reapply after a period of one (1) year from the date of the final determination.

J. Felony Convictions:
A Practitioner may reapply after a period of one (1) year has elapsed from the date of the conviction or conclusion of sentencing, incarceration/obligation, whichever is later.

K. Federal Sanctions:
A Practitioner or HDO may reapply once the sanction is lifted.

L. Other Issues of Professional Conduct or Competence:
A Practitioner or HDO may reapply after a period of one (1) year.

The CC retains, solely at its discretion, the right to reduce the period of time for the Provider to reapply.

Policy 15 Practitioner Physical & Mental Health Conditions and Impairments

The purpose of this policy is to provide guidelines for credentialing, recredentialing or interim assessments by the Credentialing Committee of Practitioners (whether current Participating Practitioners or applicants) to whom any of the following apply: 1) are acknowledged to have a mental health or Substance Abuse Condition; or 2) have undergone treatment for a mental health or Substance Abuse Condition in the past three years; or 3) have a physical impairment that may negatively impact their ability to provide care to patients or pose a risk of harm to patients. Information regarding presence or history of a Mental Health Condition(s), Substance Abuse Condition, and/or physical condition(s) and/or impairment(s) is found through disclosure on the Practitioner’s application for participation in a network, through primary source verifications or databank queries in the process of credentialing, or other credible sources.

A. Practitioners (whether current Participating Practitioners or applicants) who are identified as having a mental health or Substance Abuse Condition or conditions for which they are currently undergoing treatment or for which they have undergone treatment in the past three years, or identified to have a physical condition(s) and/or impairment(s) that could interfere with their ability to perform the scope of care expected...
by a Practitioner in his/her Specialty or whose condition could pose a risk of harm to enrollees will be
individually reviewed by the Credentialing Committee.

B. Practitioners (whether current Participating Practitioners or applicants) and who have issues related to
substance abuse must provide information that they he/she is currently in or has successfully completed an
ongoing treatment and/or monitoring program. The information reviewed must not raise a reasonable
suspicion of substandard professional conduct and competence, or that the Practitioner’s history does not
adversely affect patient safety.

C. For initial applicants, the criteria related to license status discussed in prior criteria is applicable.

D. For initial applicants who disclose information regarding substance abuse or other impairment and whose
license status has not been affected, the Credentials Committee shall use discretion to determine what
constitutes a satisfactory length of time in a treatment or a reasonable practice setting.

E. For Participating Practitioners whose license status has been affected because of substance abuse, the
information must indicate a documented period of no less than one (1) year since initiation of a successful,
supervised treatment in a program with no evidence of recidivism since that time.

F. For Participating Practitioners with substance abuse or other impairments whose license has not been
affected by the substance abuse issue or impairment, the Credentials Committee shall use discretion to
determine what constitutes a satisfactory length of time in a treatment or monitoring program and may then
require documentation in support of that requirement.

G. In any instance where there is reasonable concern regarding impairment, the Credentials Committee may,
at its discretion require whatever additional monitoring or follow up information it deems appropriate.

H. Practitioners who fit the descriptions noted above may be asked to have their treating physician submit
directly to the Credentialing Department, information noting whether their condition in any way impairs their
ability to practice or in any way poses a risk of harm to patients or raises a reasonable suspicion of
substandard professional conduct or competence. Practitioners will be required to authorize the release of
such information to the CC in order for the participation to be evaluated. Additionally, the treating physician
will be asked to agree to notify the Credentialing Department if, at any time during treatment of the
Practitioner, it becomes apparent that the Practitioner’s condition could impair the Practitioner’s ability to
practice or could pose a risk of harm to patients.

I. The information obtained will be considered when the Credentialing Committee makes its decision regarding
network participation.

PROCEDURES

A. When information is received that a Practitioner:

1. Has a Mental Health Condition and is currently undergoing treatment or has undergone treatment in the
   past three years, or

2. Has a medical condition or impairment affecting his or her ability to perform his or her professional
duties or when such information is found through primary source verifications or databank queries in the
process of credentialing, or

3. Is undergoing treatment for, or has a history of, substance abuse

B. The Practitioner may:

   Be advised, in writing, that to be considered for network participation (new or continued) it will be necessary
for the Practitioner to authorize their treating physician to provide written substantiation to the Credentialing
Department noting whether the Practitioner’s condition in any way impairs his/her ability to practice or could
pose a risk of harm to patients or suggest future probable substandard professional conduct or competence.

C. Once the letter from the treating physician is received, information from the Practitioner’s application,
including documentation from the treating physician will be individually reviewed by the Credentialing
Committee.
Policy 16 Credentialing of Certified Nurse Practitioners, Certified Nurse Midwives and Physicians Assistants

The purpose of this policy is to address the credentialing of NPs, CNMs and PAs to enable their names to be listed in a network directory when necessary to accommodate the needs of business units while clearly identifying them in a directory with the appropriate designation.

A. Application Process

To be eligible for submission of an application to credentialing, the midlevel provider must complete an initial application form. All applicable criteria related to the application requirements will be applied to midlevel providers. Specifically, providers will be required to submit information related to: licensure and any actions taken against it, education and training, malpractice coverage and history of malpractice settlements, status with regards to adverse actions taken by state and federal agencies, criminal convictions, adverse actions taken by other health care entities, and physical or mental health issues which may affect their abilities to render professional services. Applicants will be expected to attest to the accuracy of the information they supply. Issues related to DEA and/or state certificate of prescriptive authority status will be required only of those with this type of prescriptive authority (NPs, CNMs and PAs in some jurisdictions). Information regarding hospital privileges may also be applicable to CNMs, PAs, and NPs. As with other providers, the application process may be facilitated electronically.

B. Ongoing Monitoring

Midlevel providers added to the network will be subjected to the ongoing monitoring processes and will be re-credentialed every three years.

C. Completed Credentialing

On successful completion of credentialing, the NPs/CNMs/PAs name may appear in a directory. The directory listing must clearly delineate the licensure type of the midlevel.

Process, Requirements and Verification - Nurse Practitioners

1. 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.

2. 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 via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the licensing agency does not verify highest level of education, the education will be primary source verified in accordance with Credentialing Policy.

3. 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.

4. 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 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.

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

   a. 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
b. American Academy of Nurse Practitioners - Certification Program (C:\Documents and Settings\shelm\Local Settings\Temp\parparparparparparparparparparwww.aanpcertification.org). or

c. National Certification Corporation (http://www.nccwebsite.org), or

d. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) http://www.pncb.org/plistore/control/exams/ap/progs or

e. 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 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 Credentialing Policy and submitted for individual review by the Credentialing Committee.

6. If the NP has hospital privileges, they must have hospital privileges at a 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.

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

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

9. NPs will be clearly identified as such:
   a. On the credentialing file,
   b. At presentation to the Credentialing Committee, and
   c. On notification to Network Services and to the provider database.

**Process, Requirements and Verifications - Certified Nurse Midwives**

1. 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.

2. 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 via primary source verification of the license, provided that state licensing agency performs verification of the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with Credentialing Policy.

3. 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 license 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.

4. 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 procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.

5. All CNM applicants will be certified by either:
   a. The National Certification Corporation for Ob/Gyn and Neonatal Nursing, or
   b. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

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 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 Credentialing Policy and submitted for individual review by the Credentialing Committee.

6. The CNM applicant must have unrestricted hospital privileges at a 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.

7. The CNM applicant will undergo the standard credentialing process outlined in Credentialing Policies. CNMs are subject to all the requirements of these 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.

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

9. CNMs will be clearly identified as such:
   a. On the credentialing file,
   b. At presentation to the Credentialing Committee, and
   c. On notification to Network Services and to the provider database.

**Process, Requirements and Verifications - Physician’s Assistants (PA)**

1. 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.

2. 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 Credentialing Policy.

3. 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.

4. 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 procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
5. 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 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 Credentialing Policy and submitted for individual review by the Credentialing Committee.

6. If the PA has hospital privileges, they must have hospital privileges at a 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.

7. The PA applicant will undergo the standard credentialing process outlined in Credentialing Policies. PAs are subject to all the requirements described in these policies including (but not limited to): Committee review of Level II files failing to meet predetermined criteria, recredentialing every three years, and continuous sanction and performance monitoring upon participation in the network.

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

9. PA’s will be clearly identified such:
   a. On the credentialing file,
   b. At presentation to the Credentialing Committee, and
   c. On notification to Network Services and to the provider database.
ATTACHMENT A

Practitioners Specialties Not Requiring Hospital Privileges

Hospital Privilege requirements apply in general to physician providers, and thus the following provider types are excluded from this requirement. These practice types include:

1. Chiropractors
2. Podiatrists
3. Optometrists
4. Non-physician behavioral health providers (Including but not limited to: Psychologists, Social Workers, Licensed Professional Counselors, Marriage and Family Therapists/Counselors, Nurse Practitioners working in behavioral health)
5. Nurse Practitioners
6. Medical Therapists, e.g. physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing

In addition, there are several physician specialty types whose practices are primarily limited to the outpatient arena and thus are exempted from the requirement for hospital privileges. These specialties are:

1. Addiction Medicine/Addictionology
2. Allergy & Immunology
3. Dermatology
4. Genetics
5. Occupational Medicine
6. Pain Management
7. Physical Medicine & Rehabilitation (Physiatrists)
8. Psychiatry
9. Public Health and General Preventive Health
10. Rheumatology
11. Radiation Oncology practicing at a TJC- or AOA-approved Professional
12. Ophthalmology
13. Neuromusculoskeletal Medicine & Osteopathic Manipulative Medicine
14. Primary Care physicians whose patients are admitted to a participating hospital with an established hospitalist program
15. Physicians in any specialty who have been credentialed to participate solely as a Telemedicine Provider (note: if such a physician later applies to participate as an office based physician, the hospital privilege requirement may apply)
16. Anesthesiologists practicing in an outpatient setting
17. Radiologists practicing in an outpatient setting.

All other MD and DO provider types within the scope of the credentialing program, and dentists who practice as Oral-Maxillofacial Surgeons are required to have hospital privileges or appropriate admitting arrangements. This includes all PCP providers (family physicians, pediatricians, internists, & general practitioners) and Specialty Providers other than those specifically exempted by the listings above.
## Attachment B

### Accreditation Bodies and the Specific Accreditations They Offer

<table>
<thead>
<tr>
<th>Accrediting Agency</th>
<th>Professional Type Reviewed</th>
<th>Accreditations offered</th>
<th>Accreditations Acceptable for Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>TJC (Joint Committee on Accreditation of Health Care Organizations)</td>
<td>Acute Care Hospitals, Ambulatory Care Orgs, Home Health Care Orgs, Behavioral Health Care Orgs, Health Care Networks, Long Term Care Facilities, Assisted Living Facilities, Office Based Surgery Practices, Critical Access Hospitals, Clinical Labs</td>
<td>Accredited, Provisional Accreditation, Conditional Accreditation, Preliminary Accreditation</td>
<td><strong>Accredited</strong> — The organization demonstrates compliance with all of the standards at the time of the onsite survey, or it resolves. Requirements for Improvement via an acceptable evidence of standards compliance submission. <strong>Provisional Accreditation</strong> — All Requirements for Improvement have not been addressed in the evidence of standards compliance submission, or the organization has failed to achieve an appropriate level of sustained compliance as determined by a Measure of Success result (when required). Medicare-Medicaid Certification Based Long Term Care Accreditation Preliminary Accreditation (used when an organization demonstrates compliance with selected standards in compliance with selected standards in the first of 2 surveys conducted under the Early Survey Option.)</td>
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<tr>
<td>HFAP – Healthcare Facilities Accreditation Program (formerly referred to as American Osteopathic Association Hospital Accreditation Program)</td>
<td>Hospitals, Behavioral Health Facilities, Ambulatory Care/Surgery Centers, Physical Rehab Facilities, Critical Access Hospitals, Clinical Labs</td>
<td>Accreditation &amp; resurvey within 3 years, Accreditation &amp; resurvey within 2 years, Provisional or Conditional Accreditation, Accreditation &amp; resurvey within 1 year Denial</td>
<td>Accreditation &amp; resurvey within 3 years Accreditation &amp; resurvey within 2 years</td>
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Website: [www.jointcommission.org](http://www.jointcommission.org)  
Website: [www.hfap.org](http://www.hfap.org)
## Attachment B

### Accreditation Bodies and the Specific Accreditations They Offer

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<tr>
<td>NIAHO</td>
<td>Hospitals</td>
<td>Accreditation 1 year</td>
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<td>Outpatient Pediatric</td>
<td>Accreditation for 3</td>
<td>In force accreditation as confirmed by the</td>
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<td>Surgical Facilities</td>
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<td>AAAHC Accreditation</td>
<td>Ambulatory Surgery</td>
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<td>Accreditation for 3 years</td>
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<td>Association for</td>
<td>Facilities</td>
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<td>Accreditation for 1 year</td>
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<td>Free Standing Lithotripsy</td>
<td>Accreditation for 6</td>
<td>Accreditation for 1 year</td>
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<td>Health Care</td>
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<td>Outpatient surgery</td>
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<td>Commission for</td>
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### Attachment B

**Accreditation Bodies and the Specific Accreditations They Offer**

#### Continued

<table>
<thead>
<tr>
<th>Accrediting Agency</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Class “A” facilities are those where procedures are performed under local or topical anesthesia. Class “B” facilities are those where procedures are performed under local/topical anesthesia and/or IV sedation or regional anesthesia but without the use of intubation or inhalation general anesthesia. Class “C” facilities are those where procedures are performed using any anesthesia described in Class B facilities plus IV Propofol, spinal or epidural anesthesia, and endotracheal intubation.</td>
<td>6 Month Accreditation 1 year Accreditation 3 year Accreditation</td>
<td>3 year Accreditation with National Fire Code Protection (NFPA) Life Safety Code Compliance Module</td>
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</table>
| Institute for Medical Quality  
Website: [www.imq.org](http://www.imq.org) | Ambulatory Facilities |  |  |
| CARF Commission on Accreditation  
Rehabilitation Facilities  
Website: [www.carf.org](http://www.carf.org) | Medical Rehabilitation Programs: (each type has several subsets)  
Impatient Rehab  
Outpatient Medical Rehab  
Home & Community Base Rehab  
Selected Behavioral Health Programs:  
Day Treatment  
Detoxification  
Inpatient  
Outpatient  
Partial Hospitalization  
Day Treatment | Accreditation for 3 years  
Accreditation for 1 year  
Provisional Accreditation | Accreditation for 3 years  
Accreditation for 1 years |
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</thead>
<tbody>
<tr>
<td>CHAP Community Health Accreditation Program</td>
<td>Home Health, Hospice, Home Medical Equipment, Home Pharmacy, Infusion Therapy Nursing, Private Duty Services, Home Care Aide Services, Public Health, Supplemental Staffing services, Community Nursing Centers, Community Rehab Centers</td>
<td>Accreditation (revisits on 3 year cycle), Accreditation without Required Actions, Accreditation with Required Actions, Accreditation with Required Actions &amp; Progress Report, Accreditation with Required Actions, Progress Report and follow Up Focus Visit, Accreditation with Required Actions and a follow-up focus visit</td>
<td>Valid Accreditation per website</td>
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Quality Improvement Program

Quality Improvement Program Summary

For the purposes of this Quality Improvement Program Summary, the SSI Affiliates identified in Exhibit A of the Southeast Services, Inc. Agreement (or identified in the “Definition” section of the SSI Dental Provider and Oral Surgery Provider Agreements) and HealthKeepers, Inc., are collectively referred to herein as "Anthem" unless otherwise noted. HealthKeepers, Inc., may also be referred to herein as the "HMO". This Quality Improvement Program Summary shall apply to Covered Services rendered to Covered Individuals or Covered Individuals (hereafter “Covered Individuals”), except as may be otherwise provided herein. As a participating provider, you will cooperate with Anthem in connection with its implementation of this Quality Improvement Program.

Medical Record Review Policy and Procedure

The purpose of Medical Record Documentation Review is to ensure that Covered Individuals' medical records are maintained in a manner that fosters consistent, quality health care. The Anthem’s Medical Record Documentation Review criteria include the following:

- A completed problem list and medication list are documented
- Allergies are prominently displayed
- Medical history is appropriately recorded
- Pertinent history and physical exam are documented
- A follow-up plan and/or return visit is documented for each encounter
- Missed/canceled appointments are documented with follow up contact and outreach efforts
- Continuity/coordination of care between PCPs and any independent providers, including any impatient stays, is documented
- Consultant, lab, and imaging studies reflect provider review
- Immunization record is complete (for pediatric Covered Individuals only- below age 16)
- Preventive services are appropriately recommended, noted and used
- Health guidance/counseling is appropriately provided to Covered Individuals
- A copy of signed Advance Directive, or evidence of Advanced Directive discussion with appropriate Covered Individual, is prominently displayed in the medical record (for all Senior and/or Medicare Advantage Covered Individuals and those with chronic or catastrophic illnesses)
- A record system that maintains the confidentiality of the Covered Individual is used
- A written policy is in place, addressing the confidentiality of patient information, with evidence of staff receiving periodic training in Covered Individual information confidentiality

Anthem periodically monitors providers’ medical record documentation via a random selection of records. Records must be made available, or can be copied and sent to Anthem for review. After the review, Anthem communicates any deficiencies to affected providers. As appropriate, the Anthem implements general and/or specific focused actions with the provider network or with specific providers aimed at improving medical record documentation. Anthem conducts focused follow-up with specific providers who have performed poorly against standards.
Provider Site Review Policy and Procedure

The purpose of Provider Site Review is to ensure that Covered Individuals are provided with a network of providers who meet office practice and accessibility criteria. As a participating provider, you will grant Anthem access to any of your offices within 30 days of Anthem’s request for the purpose of Provider Site Review. Anthem’s office review criteria include, but are not limited to, standards around the following:

1. Physical Accessibility, especially for individuals with special needs
   a. Handicap accessibility
   b. Well-lit waiting rooms
   c. Posted office hours
2. Physical Appearance
   a. Cleanliness/Pleasantness of the waiting area
   b. Cleanliness/Pleasantness of the treatment room
3. Adequacy and appearance of waiting room space
   a. Adequate seating in waiting room
   b. Adequacy of supplies in treatment room
   c. Adequacy of space in treatment room
4. Adequacy of medical/treatment record keeping
   a. Confidentiality
   b. Organization

Upon receipt of a Covered Individual complaint or complaints related to any of the issues listed in numbers 1-4 above, which when assessed against the criteria established in the Anthem’s complaint policy exceed threshold, a site visit will be performed. This visit will be performed by an Anthem associate, and will occur within 60 days of receipt of the Covered Individual complaint or complaints that exceed threshold.

A site evaluation meeting standards will be documented as such and the practitioner notified. No further action is required. When a site evaluation does not meet standards the office will be notified and a corrective action plan will be requested and followed up on in a mutually agreed upon timeframe. If a site fails to correct identified deficiencies, the issue will be referred to appropriate quality committee for additional review and action.

- Anthem’s medical/surgical appointment access criteria include the following:
- Urgent Care within 24 hours
- After Hours Care: Covered Individual ability to reach a recorded message or live voice response providing emergency instructions and for non-emergent (urgent) matters information when to expect to receive a call back
- Routine Non-Emergency or Non-Urgent Care within 14 days
- Preventive Care within 60 days

For maternity care, the Contractor shall be able to provide initial prenatal care appointments for pregnant Covered Individuals as follows:

- First trimester - within fourteen (14) calendar days of request
- Second trimester - within seven (7) calendar days of request
- Third trimester - within three (3) business days of request

Appointments shall be scheduled for high-risk pregnancies within three (3) business days of identification of high risk to the Contractor or maternity provider, or immediately if an emergency exists.
Anthem’s behavioral health appointment access criteria include the following:

- Non-Life-Threatening Emergency Care immediately upon Covered Individual’s request Urgent Care within 24 hours
- Routine Care within 10 working days

In addition, Anthem conducts Provider Site Reviews on an as needed basis if potential issues with an office are identified through the monitoring of Covered Individual complaints, analysis of practice specific Covered Individual surveys, feedback from Anthem’s staff, and/or other data. As above, Anthem communicates results with the provider office and conducts a follow-up Provider Site Review to assure that deficiencies are corrected.

Quality of Care Issues Policy and Procedure

The purpose of Anthem's Quality of Care Issues monitoring is to identify and act on potential instances of poor clinical quality or safety which may impact Covered Individuals.

Anthem identifies potential Quality of Care Issues during the prospective, concurrent, or retrospective review process, the Covered Individual complaint resolution process, and/or the medical record review process or clinical audit process. Anthem conducts an investigation of all potential Quality of Care Issues and takes appropriate action based on the severity of issues. As a participating provider, you will comply with any corrective action plans directed by Anthem as the result of a Quality of Care Issue.

Role of Participating Providers in the Covered Individual Complaint Process

Anthem provides Covered Individuals a mechanism that allows them to register complaints with Anthem. Complaints may be received from Covered Individuals or from representatives acting on behalf of Covered Individuals. All complaints concerning network providers and/or their staff are investigated to determine whether complaints received about providers are of a service or clinical nature.

Clinical and Service Related Complaints

For clinical related complaints, Anthem requests a response from the provider and medical records (if necessary). As a participating provider, you will respond to all clinical related complaints and provide medical records (if necessary) to Anthem within 10 business days. If no response is received within 10 business days, Anthem and/or Anthem medical director will follow-up with the provider. Clinical related complaints are forwarded to Anthem’s medical director for review and resolution, which may include peer review.

For service related complaints, Anthem works with the provider and/or office staff to resolve issues.

For those providers that Anthem requested complaint-related information from, a resolution letter is mailed informing him/her of the outcome and any recommended actions, as applicable. The resolution letter will be mailed within 90 calendar days of receipt of the complaint.

All complainants are notified in writing of the disposition of their complaint within 30 calendar days of the receipt of the complaint. If the complaint is unable to be resolved within 30 calendar days, the complainant is notified that additional time is required to resolve the complaint. Anthem will then resolve the complaint and notify the complainant of the disposition of the complaint within an additional 30 calendar days. Anthem compiles complaint reports to be reported to state and federal entities, as appropriate.

Anthem reviews all providers’ history of Covered Individual complaints at least every six months. If necessary, appropriate action is taken with providers. Covered Individuals complaints about providers also trigger a site visit when the established threshold is met. Please see Provider Site Review Policy section of the exhibit for further details.

Anthem HealthKeepers Plus

All complainants are notified in writing of the disposition of their complaint within 30 business days of the receipt of the complaint. If the complaint is unable to be resolved within 30 business days, the complainant is notified that additional time is required to resolve the complaint. Anthem will then resolve the complaint and notify the complainant of the disposition of the complaint within 30 calendar days. Anthem compiles complaint reports to be reported to state and federal entities, as appropriate.
Anthem HealthKeepers Plus - Medallion II

All complainants are notified in writing of the disposition of their complaint within 30 days of the receipt of the complaint. The 30-day time frame may be extended up to 30 calendar days if an extension is requested. It may also be extended by 30 calendar days if we provide evidence to the Department of Medical Assistance Services proving that a delay in making a decision is in your best interest.

For Anthem HealthKeepers Plus (both FAMIS and MEDALLION II), Anthem reviews all providers' history of Covered Individual complaints at least every six months. If necessary, appropriate action is taken with providers. Covered Individuals complaints about providers also trigger a site visit when the established threshold is met. Please see Provider Site Review Policy section of the exhibit for further details.

Diagnostic Imaging Accreditation

Within 30 days of receipt of a written request, participating provider shall provide to Anthem such information as may be requested concerning diagnostic imaging services, equipment, licensure and/or accreditation. Participating providers shall provide such information in the manner and format reasonably required by Anthem (including, without limitation, using a web-based tool). Additionally, after making its original submission of this information to Anthem, whenever any material change occurs with respect to Provider's diagnostic imaging services, equipment, licensure and/or accreditation, Provider shall update Anthem on such change within 30 days of the change (unless a shorter timeframe is required elsewhere in this Agreement).

Providers that perform or conduct any Ultrasound, CT, CTA, MRI, MRA, MRS, PET, Cardiac Echocardiography and/or Nuclear/Nuclear Cardiology studies shall be accredited by the American College of Radiology (ACR), Intersocietal Accreditation Commission (IAC), American Institute of Ultrasound in Medicine (AIUM) or the American Society of Breast Surgeons (ASBS) for each piece of equipment utilized in such studies. Provider has one year from the acquisition of the modality to obtain accreditation.

Provider will make no charge and render no bill to any Plan, the Covered Individual, or the Covered Individual’s guarantor for any of the studies listed above, and they shall have no obligation to make any payment to anyone, including Provider, for such studies, unless the studies are performed on accredited equipment as specified above.
Enterprise Audit Policy

Enterprise Audit Policy

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

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

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Anthem and Provider 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 Anthem Covered Individual(s).

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

- Appeal Response means Anthem’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 to be 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 believes an overpayment has been made by Anthem identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit that constitute the basis for Anthem’s 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 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 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 Providers or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which payment 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.
Procedure:

1. **Review of Documents.** Plan or its designee will request in writing or verbally, final and complete itemized bills for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Plan within thirty (30) calendar days of Plan’s request.

2. **Scheduling of Audit.** After review of the documents submitted, if Plan determines an Audit is required, Plan will call the Provider or Facility to request a mutually satisfactory time for Plan 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 the Plan 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 Plan 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 Plan during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Plan for adjudication.

5. **Scheduling Conflicts.** Should the Provider or Facility fail to work with Plan in scheduling or rescheduling the Audit, Plan retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Plan may invoke at any time. While Plan prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Plan must respond quickly to requests by regulators or its clients. In those circumstances, Plan 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.** Plan may conduct Audits from its offices or on-site at the Provider’s or Facility’s location. If Plan conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for Plan’s on-site Audit activities. During the Audit, Plan 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 review, Provider or Facility will give Plan or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Plan or its designee will have complete access to Provider’s or Facility’s patient accounting system to review payment history, explanation of benefits (EOB), notes and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Plan access to the items requested to complete the Audit, Plan may opt to complete the Audit based on the information available. All Audits shall be conducted free of charge despite any Provider or Facility policy to the contrary.

7. **Completion of Audit.** Upon completion of the Audit, Plan 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, Plan 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 Plan, then Provider may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Plan 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 Appeal’s.** 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 Plan will process adjustments to recover amount identified in the final Audit Report.
**Documents Reviewed During an Audit:**

The following is a description of the documents that may be reviewed by the Plan 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 physician's 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 Plan'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. Plan 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.

**Exceptions:** This Audit Appeal Policy does not apply to Medicare Advantage, Medicare Private Fee for Service or New York physician Claims.

**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 within thirty (30) calendar days of the date of the Audit Report. 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. If no Supporting Documentation is submitted to substantiate the basis for the Provider's or Facility's belief that a particular finding is not accurate the Provider or Facility will be notified of the denial and have thirty (30) calendar days to send a remittance check to Anthem, if applicable in the state. If no remittance check is received within the thirty (30) day timeframe or if Provider or Facility does not respond to an Audit Report within thirty (30) calendar days of the date of such Report, Anthem will begin Recoupment proceedings within ten (10) days, unless expressly prohibited by an Agreement.

2. A Provider's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem 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 or within thirty (30) calendar days of the receipt of Anthem's appeal response and submitted to the Appeals coordinator identified within the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's sole discretion, for up to thirty (30) calendar days from the
date the Appeal would otherwise have been due. A written notification of approval or denial of an Appeal extension will be mailed to the Provider or Facility within seven (7) calendar days. 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 shall issue an Appeal Response to the Provider or Facility. Anthem’s response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem’s response shall be sent via certified mail to the Provider or Facility within sixty (60) calendar days of the date Anthem 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 thirty (30) calendar days from the date of Anthem’s response to send a response or, if applicable in the state, a remittance check to Anthem. If no Provider or Facility response or remittance check (if applicable) is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem’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 shall formulate a final Appeal Response. Anthem’s final Appeal Response shall address each matter contained in the Provider’s or Facility’s response. If appropriate, Anthem’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 final Appeal Response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem 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 thirty (30) calendar days from the date of Anthem’s final Appeal Response to send a remittance check to Anthem. If no remittance check is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem’s final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.
360° HEALTH®

What is 360° Health®?

It's one of the industry's most comprehensive health services programs. In fact, this brand new integrated group of health services is designed to help Anthem Covered Individuals:

- Manage and maintain their health
- Make more informed health care decisions
- Maximize the value of their health care benefits

We developed 360° Health® because we want our Covered Individuals to be completely surrounded with the information they need to manage their health. This new program offers Covered Individuals access to services ranging from preventive care, case management and care coordination, such as:

- Online health and wellness resources
- Discounts on health-related products and alternative medicine therapists
- Twenty-four/seven (24/7) professional guidance and support
- Condition management to help those with serious health issues

In a nutshell, 360° Health includes tools that our Covered Individuals and their families can use to manage their health care needs. Please see the information listed below for details about this revolutionary program!

How Health Needs are Being Met with 360° Health

Health Resources

If having access to a wealth of health and wellness information is what our Covered Individuals crave, then they can tap into:

Healthy Living, powered by WebMD® - a resource of information for Covered Individuals; including health assessments, links to articles, alerts and recalls, tools and calculators.

Covered Individual Newsletters – a newsletter for Covered Individuals that includes detailed information about various health topics.

Women's Health E-Newsletter – a free monthly newsletter created for women of all ages.

Preventive Care Guidelines – review guidelines on health issues for women, men, children and youth.

On-Call's® Audio Health Library – listen to recorded messages addressing hundreds of general health topics in English and Spanish by calling (866) 277-2367.

Health Extras

Our interactive tools and health discounts will help Covered Individuals save money and learn more about keeping themselves healthy with resources like:

Healthy Extensions Discounts – discounts are available for alternative therapies, vision and dental services, hearing aids, fitness club Covered Individuals and weight management programs.

Interactive online programs offered by WebMD® – access items such as tracking tools for diet, fitness and medication needs.

The Last Cigarette ("TLC") – a smoking cessation program that helps Covered Individuals and their families live smoke free.

Walking Works – a program that helps Covered Individuals walk their way to better health.
**Health Guidance**

There’s nothing like being able to receive helpful information twenty-four/seven 24/7 on different events (such as before, during or after a Professional stay). And, with 360° Health, Covered Individuals can use the tools that are right for them:

**Access an online database for Professional quality** – Covered Individuals preparing for a Professional stay will probably have questions about the Professional that will be providing their care. That is why we provide an online tool to help Covered Individuals educate themselves about the Facilities available to them. To learn more, registered Covered Individuals can log on to Healthcare Advisor by Subimo® by visiting the Covered Individual Access section of the Anthem Web Site (www.anthem.com).

**BlueChoice On-Call®** – Health issues don’t follow a nine to five (9 to 5) schedule. That is why Covered Individuals can speak with a registered nurse twenty-four/seven 24/7 by calling (866) 277-2367.

**Baby Connection** – Studies have indicated that many preterm births can be avoided with the right prenatal care. Covered Individuals may activate their Covered Individual in our maternity management program, as well as find answers and support by calling (866) 664-5404.
Centers of Medical Excellence ("CME")

**Centers of Medical Excellence ("CME")**

The CME designation is awarded by Wellpoint to those programs meeting the participation requirements for WellPoint's transplant Network and all other future specialty Networks developed by WellPoint. Each center is selected through a rigorous evaluation of clinical data that provides insight into the Professional'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.

**Blue Distinction® Centers of Excellence Programs**

Blue Distinction® is a designation awarded by the Blue Cross and Blue Shield companies to medical Facilities that have demonstrated expertise in delivering quality healthcare. The designation is based on rigorous, evidence-based, objective selection criteria established in collaboration with expert physicians’ and medical organizations’ recommendations. Its goal is to help consumers find quality specialty care on a consistent basis, while enabling and encouraging healthcare professionals to improve the overall quality and delivery of care nationwide.

At the core of the Blue Distinction program are the Blue Distinction Centers for Specialty Care®, Facilities that we recognize for their distinguished clinical care and processes in the areas of:

- Bariatric Surgery
- Cardiac Care
- Complex and Rare Cancers
- Knee and Hip Replacement
- Spine Surgery

**Blue Distinction® Centers for Transplants**

The Blue Distinction® Centers for Transplants program is a program designated by the Blue Cross Blue Shield Association to facilities that meet objective, evidence-based thresholds for clinical quality, developed in conjunction with expert physicians and medical organizations.

Blue Distinction® Centers for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. They offer comprehensive transplant services through a coordinated, streamlined transplant management program. To date, they have designated more than 80 facilities nationwide – representing more than 330 transplant programs that meet evidence-based selection criteria.

Additional value-added services provided within this transplant network include global pricing, financial savings analysis and global claims administration support, as well as support services such as referral management, patient satisfaction survey reports and transplant-related continuing education programs for Blue companies.

The Blue Distinction® Centers for Transplants program examines the following transplant types:

- heart
- lung (deceased and living donor)
- combination heart/lung
- liver (deceased and living donor)
- simultaneous pancreas kidney (SPK)
- pancreas (PAK/PTA)
- bone marrow/stem cell (autologous & allogeneic)
**Preventable Adverse Events**

**Preventable Adverse Events Policy**

**Acute Care General Hospitals - PAE Policy**

**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 Anthem or the Covered Individual for such events. If acute care general hospital receives any payment from Anthem 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, to the extent reasonable, 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.

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<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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<td>3. Wrong surgical procedure performed on a patient</td>
<td>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.</td>
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**CMS Hospital Acquired Conditions ("HAC")**

Anthem follows CMS’ current and future recognition of HACs. Current and valid 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 Anthem for payment. In no event shall the charges or days associated with the HAC be billed to either Anthem or the Covered Individual.
Providers and Facilities (excluding Acute Care General Hospitals) – PAE Policy

Four(4)MajorSurgicalNeverEvents

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 Anthem or the Covered Individual for such events. If Provider or Facility receives any payment from Anthem 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, to the extent reasonable, 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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<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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Insurance Requirements

Provider must provide Anthem with proof of professional liability insurance and a record of professional liability activity upon our request. Physicians must provide proof of professional liability insurance of not less than $1,000,000 per occurrence and $3,000,000 in the aggregate. Non-physician behavioral health practitioners must provide proof of professional liability insurance of not less than $1,000,000 per occurrence and $1,000,000 in the aggregate.
FEP Program Requirements

FEP Program Requirements

Providers acknowledge and understand that Anthem participates in the Federal Employee Health Benefit Program (FEHBP) – the health insurance Plan for federal employees. Providers 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, FEP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employee Health Benefit Program

All Claims under the Federal Employee Health Benefit Program ("FEHBP") must be submitted to Plan for payment within one year from the date of discharge or from the date of the primary carrier'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 payer, the one year 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 year period. Except where Covered Individual did not provide Plan identification, Network/Participating Provider shall not bill, collect or attempt to collect from Covered Individual for Claims Plan receives after the applicable period regardless of whether Plan pays such Claims.

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

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

Coordination of Benefits for the Federal Employee Health Benefits Program

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 FEP as secondary payer, might not equal the entire amount billed by the provider for covered services.

Federal Employee Health Benefits Program Waiver requirements

- Notice must identify the proposed services
- Inform the member that services may be deemed not medically necessary, experimental/investigational, or cosmetic by the Plan
- Provide an estimate of the cost for the service
- Member must agree in writing to be financially responsible in advance of receiving the services

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Risk Adjustments Related to Federal Exchanges Products

Compliance with Federal Laws, Audits & Record Retention Requirements

Medical records and other health and enrollment information of Covered Individuals enrolled under a Federal Exchanged Product 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
- 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 enrolled under a Federal Exchanged Product, Anthem, Providers and Facilities, are obligated to abide by all Federal and state laws regarding confidentiality and disclosure for medical health records (including mental health records) and enrollee information.

Encounter Data for Risk Adjustment Purposes

Commercial Risk Adjustment and Data Submission: Risk adjustment is the process used by Health and Human Services (HHS) to adjust the payment made to the Federal Exchange products based on the health status of the Exchange Covered Individuals enrolled under a Federal Exchanged Product. Risk adjustment was implemented to pay health plans participating in Exchanges more accurately for the predicted health cost expenditures of Covered Individuals enrolled under a Federal Exchanged Product by adjusting payments based on demographics (age and gender) as well as health status. As an Exchange participating organization, diagnosis data collected from encounter and claim data is required to be submitted to HHS for purposes of risk adjustment. Because HHS requires that Exchange Participating Organizations submit “all ICD9 codes for each beneficiary”, Anthem Blue Cross and Blue Shield (Anthem) also collects diagnosis data from the medical records of the Covered Individuals enrolled under a Federal Exchanged Product created and maintained by the Provider.

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

RADV Audits

As part of the risk adjustment process, HHS will perform a risk adjustment data validation (RADV) audit in order to validate the diagnosis data of the Covered Individual enrolled under a Federal Exchange Product that was previously submitted by Exchange Participating Organizations. These audits are typically performed once a year. If the Exchange participating Organization is selected by HHS to participate in a RADV audit, the Exchange participating Organization and the Providers that treated the Covered Individuals enrolled under a Federal Exchange Product included in the audit will be required to submit medical records to validate the diagnosis data previously submitted.

ICD-9 CM Codes

HHS requires that physicians currently use the ICD-9 CM Codes (ICD-9 Codes) or successor codes and coding practices for Exchange product business. In all cases, the medical record documentation must support the ICD-9 or successor Codes selected and substantiate that proper coding guidelines were followed by the Provider. For example, in accordance with the guidelines, it is important for physicians to code all conditions that co-exist at the time of an encounter and that require or affect patient care or treatment. In addition, coding guidelines require that the Provider code to the highest level of specificity which includes fully documenting the patient’s diagnosis.

Medical Record Documentation Requirements. Medical records significantly impact risk adjustment because:

- They are a valuable source of diagnosis data;
- They dictate what ICD-9 or successor Code is assigned;
- They are used to validate diagnosis data that was previously provided to HHS by the Exchange participating organizations.
Because of this, the Provider and Facility play an extremely important role in ensuring that the best documentation practices are established.

- HHS record documentation requirements include:
- Patient’s name and date of birth should appear on all pages of record.
- Patient’s condition(s) should be clearly documented in record.
- The documentation must show that the condition was monitored, evaluated, assessed/addressed or treated (MEAT).
- The documentation describing the condition and MEAT must be legible.
- The documentation must be clear, concise, complete and specific.
- When using abbreviations, use standard and appropriate abbreviations. Because some abbreviations have different meanings, use the abbreviation that is appropriate for the context in which it is being used.
- Physician's signature, credentials and date must appear on record and must be legible.