Anthem Blue Cross and Blue Shield
Professional 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.

Important Note:

The information in this manual does not apply to Medicare Advantage, Medicaid (HMO) or Medicare Medicaid Plan Demonstration (HealthKeepers, Inc.). You can find the manuals for these plans by going to www.anthem.com > providers > select your state (Virginia) and enter > Plans & Benefits > scroll and select the plan.

Legal and Administrative Requirements Overview

Fair Business Practice Act (FBPA)

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. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. section 1397aa et seq. (CHIP), 5 U.S.C. section 8801 et seq. (federal employees), or 10 U.S.C. section 1071 et seq. (TRICARE); or (ii) accident only, credit or disability insurance, long-term care insurance, TRICARE 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 30 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 60 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, downcoding, 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 downcodes claims submitted by a provider, the
carrier shall clearly disclose that practice in each provider contract. Further, such carrier shall
either (1) disclose in its provider contracts or on its website the specific bundling and
downcoding 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 (2) disclose to each provider contract a
telephone or facsimile number or e-mail address that a provider can use to request the specific
bundling and downcoding 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 10 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:

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

b. 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) 12 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 30 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.

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. 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 section 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 section 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:

1. Coverage's issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid), Title XXI of the
Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE);

2. The state employee health insurance plan established pursuant to section 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 section 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.

Insurance Requirements

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

1. Professional liability/medical malpractice liability insurance which limits shall comply with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render those services addressed by this Agreement. In states where there is an applicable statutory cap on malpractice awards, Providers shall maintain coverage with limits of not less than the statutory cap.

   If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers agree to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years.

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

3. Commercial general liability insurance for Providers with limits of not less than $1,000,000 per occurrence and $2,000,000 in the aggregate for bodily injury and property damage, including personal injury and contractual liability coverage.

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

- Auto Liability insurance which complies with all applicable state laws and/or regulations, and shall provide coverage for claims arising out of acts, errors or omissions in the rendering or failure to render services, but at no time shall total limits be less than $500,000 combined single limit.

For Air Ambulance Providers Only, in addition to the above:

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

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

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

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

Misrouted Protected Health Information (PHI)

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

Risk Adjustments

Compliance with Federal Laws, Audits and Record Retention Requirements

Medical records and other health and enrollment information of Covered Individuals must be handled under established procedures that:

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

In addition to the obligation to safeguard the privacy of any information that identifies a Covered Individual, Anthem, and Providers 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 health plans under the Affordable Care Act based on the health status of Covered Individuals who are insured under small group or individual health benefit plans compliant with the Affordable Care Act (aka ACA Compliant Plans). Risk adjustment was implemented to pay health plans more accurately for the predicted health cost expenditures of Covered Individuals by adjusting payments based on demographics (age and gender) as well as health status. Anthem, as a qualifying health plan, is required to submit diagnosis data collected from encounter and claim data to HHS for purposes of risk adjustment. Because HHS requires that health plans submit all ICD10 codes for each beneficiary, Anthem also collects diagnosis data from the Covered Individuals’ medical records created and maintained by the Provider.

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

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

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

**RADV Audits**

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

**ICD-10 CM Codes**

HHS requires that physicians use the ICD-10 CM Codes (ICD-10 Codes) or successor codes and coding practices services under ACA Compliant Plans. In all cases, the medical record documentation must support the ICD-10 Codes or successor codes selected and substantiate that proper coding guidelines were followed by the Provider. 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-10 Code or successor code is assigned; and
- They are used to validate diagnosis data that was previously provided to HHS by the health plans.

Because of this, the Provider plays 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.
Directory of Services

Availity®

Anthem offers an array of online tools through the Availity® Health Information Network. Availity’s secure multi-health plan portal – available at no charge to physicians and other providers – improves efficiencies through simplified and streamlined health plan administration. Availity is health information when and where you need it – and that benefits patients, providers and health plans.

Get the information you need instantly

- Member eligibility and benefits inquiry
- Claim status inquiry - See details and payment information including claim line-level details/processing.
- Availity CareProfile® - View real-time, consolidated view of a member’s medical history based on claims information across multiple providers
- Clinical Messages - Receive clinical alerts on members’ care gaps and medication compliance indicators, when available.
- Member Certificate Booklet – View a local plan member’s certificate of coverage, when available.
- Online Remits – Link to online remits under Claims Management/Remittance Review (Functionality will be available later this year. Check site for update)
- Secure Messaging – Allows a user to send a question online about a claim.

Take Advantage of These Availity Benefits

- No charge – Health plan transactions are presented at no charge to providers
- Accessibility – Availity is available 24 hours a day to registered users from any computer with Internet access.
- Standard responses – Availity returns responses from multiple payers in a standard format for a consistent look and feel.
- Access to both commercial and government payers – users can access data from Anthem, Medicare, Medicaid and other commercial insurers (See www.Availity.com for a full list of payers.)
- Compliance – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

How to get started....
To register for access to Availity, go to www.Availity.com/providers/registration-details/. It’s that simple!!

Once you log into the secure portal, you’ll have access to many resources to help jumpstart your learning, including free live training, frequently asked questions, and comprehensive help topics. Client service representatives are also available Monday through Friday to answer your questions at 800-AVAILITY (800-282-4548).

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

Point of Care

Anthem Point of Care is our secure online provider tool that’s available to participating providers that offers additional information for access to:

Medical Management:
- Primary Care Physicians can submit referrals (specialty care reviews) and fax referral information to specialists and hospitals
- Hospitals and specialists can view referrals for their patients.
- Hospitals and admitting physicians can submit requests for admission reviews.
Utilization Review/Case Management Departments and attending physicians can update clinical information and ask for extension of hospital stays.

View authorizations of outpatient procedures (health services reviews).

Providers can determine whether or not a prior authorization (health services review) is required for an outpatient procedure.

The information is available 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. To register for Point of Care go to www.anthem.com > at the top of the page select provider > Enter your state > Select Availity & Point of Care Enroll/Update (found of the left hand side of the page) > Create New Access

Provider Reports:
- View Weekly Payment Vouchers (Remits), PCP Member Reports, Error Notifications and other relevant reports (Functionality to view Payment Vouchers (Remits) will move to Availity later this year. Check site for update)

Other Valuable Company Resources:

The Provider Home Page of www.Anthem.com provides additional resources under the following topics:

- Health & Wellness
- Plans & Benefits
- Answers @ Anthem
- Communications
- Join Our Networks

Contact Us: (Listing of useful Telephone numbers)
http://www.Anthem.com/wps/portal/ahpprovider?content_path=provider/va/f5/s5/t0/pw_ad076697.htm&rootLevel=4&state=va&label=Contact%20Us

Electronic Data Interchange (EDI)
www.Anthem.com/edi

Medical Policy and Clinical UM Guidelines Link

Centers of Medical Excellence
http://www.bcbs.com/innovations/bluedistinction

BlueCard Website
http://www.bcbs.com

Federal Employee Program (FEP) Website
http://www.fepblue.org/

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

Medicaid Provider Website
http://www.anthem.com/mediproviders

Medicare-Medicaid Plans Provider Website
http://www.anthem.com/mediproviders
## Eligibility and Claims Submission (Professional Provider Billing Guidelines)

<table>
<thead>
<tr>
<th>WHO</th>
<th>Anthem Blue Cross and Blue Shield in Virginia (VA) defines “professional providers” as health care providers who submit Claims for covered 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>
<tbody>
<tr>
<td>WHAT</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>
</tr>
<tr>
<td>WHY</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>
</tr>
</tbody>
</table>
| 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. If you would like to become an electronic submitter see the EDI section of this document.  

For the remaining claims submitted on paper for all Anthem products except FEP and CareMore (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  

Paper claims for FEP can be sent to:  

**Federal Employee Program**  
P.O. Box 105557  
Atlanta, GA 30348-5557  

Paper claims for CareMore can be sent to:  

**CareMore Claims Department**  
P.O. Box 366  
Artesia, CA 90702-0366 |
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 837P 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.

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 Where to File BlueCard Claims Northern VA/DC Service Area Grid below.)

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

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.

See the BlueCard® Program Overview Section for more detail about the BlueCard® Program and links to the BlueCard® Provider Manual.

<table>
<thead>
<tr>
<th>BLUECARD® for CERTAIN ANCILLARIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>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:</td>
</tr>
<tr>
<td><strong>Independent Clinical Laboratory (Lab)</strong> – Claims must be filed to the BC/BS Plan where the specimen was collected which is determined by where referring provider is located.</td>
</tr>
<tr>
<td><strong>Durable/ Home Medical Equipment and Supplies (DME)</strong> – Claims must be filed to the BC/BS Plan where the equipment was delivered or where it was rented/purchased at a retail store.</td>
</tr>
<tr>
<td><strong>Specialty Pharmacy</strong> – Claims must be filed to the BC/BS Plan where the prescribing/ordering physician is located.</td>
</tr>
<tr>
<td><strong>Air Ambulance (fixed- and rotary-wing)</strong> - claims must be filed to the BC/BS Plan where the point of pick-up zip code is located. The pick-up zip code should be placed in the “prior approval number” section of the professional claim form.</td>
</tr>
</tbody>
</table>
Anthem’s Service Area: The entire state of Virginia EXCEPT the City of Alexandria, Arlington County and Fairfax County that is east or inside of VA Route 123 (including Fairfax City and the town of Vienna).

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

NOTE: For Providers in Fairfax City or the Town of Vienna your service area falls in both jurisdictions. Therefore, please contact your Provider Network Manager to further clarify the appropriate service area by review of the complete 9 digit zip code.

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 patients coverage (see column header 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 and Specialty Pharmacy) should follow the National BCBSA mandate referenced above.

If your Office Location where patient is treated in And, Your Provider Contract Status by network is For Anthem VA cardholders, Send Claims To: For CareFirst (DC) cardholders, Send Claims To: For cardholders of all other Blue, Send Claims To:

<table>
<thead>
<tr>
<th>Anthem Blue Cross and Blue Shield Service Area (West/Outside of VA Route 123)</th>
<th>YES w/VA #1 NO w/DC</th>
<th>ANTHEM</th>
<th>ANTHEM</th>
<th>ANTHEM</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES w/VA #2 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>ANTHEM</td>
<td></td>
</tr>
<tr>
<td>NO w/VA #3 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>ANTHEM</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CareFirst Blue Cross Blue Shield Service Area (East/Inside of VA Route 123)</th>
<th>YES w/VA #1 NO w/DC</th>
<th>ANTHEM</th>
<th>CAREFIRST</th>
<th>CAREFIRST</th>
</tr>
</thead>
<tbody>
<tr>
<td>YES w/VA #2 YES w/DC</td>
<td>ANTHEM</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
<td></td>
</tr>
<tr>
<td>NO w/VA #3 YES w/DC</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
<td>CAREFIRST</td>
<td></td>
</tr>
</tbody>
</table>

FEP Relative to the VA 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 10)
- **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.

**Exceptions:** These provider specialties may submit Claims using their group or organizational NPI number only if designated by Anthem as “group exempt billable”: 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).

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**EDI**

**Electronic Data Interchange (“EDI”) Overview**

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

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

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

**Additional Information**

For additional information concerning electronic Claims submission and other electronic transactions, you can click the Electronic Data Interchange (EDI) link below or go to [www.anthem.com/edi](http://www.anthem.com/edi) and select the appropriate state.

The **ANSI ASC X12N** subcommittee developed nine standard health care transactions to support HIPAA requirements for administrative simplification. They include:

- **837P**: Professional Health Care Claim
- **837D**: Dental Health Care Claim
- **835**: Health Care Claim Payment/Remittance Advice
- **270/271**: Health Care Eligibility Benefit or Coverage Request/Response
- **276/277**: Health Care Claim Status Request/Response
- **278**: Health Care Services Review Request for Review and Response

Organizations using electronic commerce to perform transactions covered by HIPAA must consistently comply with the applicable ANSI ASC X12N standards.
### 837P ELECTRONIC Claim

Anthem has created an online *Anthem HIPAA Companion Guide* for providers and clearinghouses to follow, helping to promote the correct formatting of all electronically submitted Claims for Anthem Covered Individuals.

Details on the 837P Claim and 835 remittance, as well as other standard transactions in the 270 series are included. Access to this guide, as well as a 5010 guide and other helpful EDI information can be found online in the dedicated EDI section of the Anthem (VA) provider portal.

**Directions to this guide:**
Go to [http://www.anthem.com/edi](http://www.anthem.com/edi); select VA; select Documents; select Companion Guide.

Other information contained online in the EDI section includes: EDI registration forms and information
EDI contacts and support information
EDI communications and electronic submission tips
Electronic filing and cost-savings benefits
Acknowledgments and Reports descriptions
FAQs about electronic transactions

Providers can contact the EDI Solutions Help Desk by phone or e-mail. A *LiveChat* feature is also available from the site itself.

### CMS-1500 PAPER Claim

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 on the most current version as distributed by the nucc.org website 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 (“O”, “I”) 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.

<table>
<thead>
<tr>
<th>ADJUSTMENT REQUESTS</th>
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<tbody>
<tr>
<td>If Provider believes a Claim has been improperly adjudicated for a Covered Service for which Provider timely submitted a Claim to Plan, Provider must submit a request for an adjustment to Plan within one (1) year from the date of Plan's payment or explanation of payment. Requests for adjustments submitted after this date may be denied for payment, and Provider will not be permitted to bill Anthem, Plan, or the Covered Individual for those services for which payment was denied.</td>
</tr>
<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 electronic “SECURE MESSAGE” from the Claims Detail screen on Availity.com, or submit a manual Anthem #151 Claim Information/Adjustment Request form on paper by downloading this form from the anthem.com provider portal.</td>
</tr>
<tr>
<td><strong>NOTE:</strong> Receipt by Anthem of requests should occur within 30 days of the Claim adjudication (process) date. Adjustment requests will not be considered if received after 12 months from the Claim adjudication date</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MODIFIERS</th>
</tr>
</thead>
<tbody>
<tr>
<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>
</tr>
<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 (see Reimbursement Policies <strong>0017: Modifier Rules</strong>).</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 see Reimbursement Policies <strong>0017: Modifier Rules</strong>.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CLAIM ATTACHMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Details regarding the process of sending paper attachments for 837’s 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 Health Care Claim and look for PWK.</td>
</tr>
<tr>
<td>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>
## REFUNDS/Overpayments

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

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

### Anthem Identified Overpayment (aka “Solicited”)

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

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

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

Providers may request immediate recoupment by signing the authorization form on the request letter and faxing it to the number indicated. **Note:** This is a dedicated tax number for immediate recoupment notification and should not be used to submit disputes or any other inquiries.

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

### Provider Identified Overpayments (aka “voluntary” or “unsolicited”)

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

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

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

- **Provider Overpayment Form (see directions below for how to access online)**
- All documents supporting the overpayment including EOBs from Anthem and other carriers as appropriate
- Covered Individual ID number
- Covered Individual’s name
- Claim number
- Date of service
- Reason for the refund as indicated in the list above of common overpayment reasons

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

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

To download the “Provider Overpayment Form” directly from anthem.com, select, “Providers” and choose VA from the drop down box and press enter. On the provider home page, select Answers@Anthem on the menu bar. On the Answers@Anthem page, select “Provider Forms” then “Provider Overpayment Form”.

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

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

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

**APPEALS**

**Information about provider dispute and appeal mechanisms** can be found on www.anthem.com > providers > Select your state > Answers@Anthem and select claims > Select Claim Reconsideration and Appeals.

**Information about the Appeal Policy and Procedure** can be found on www.anthem.com > providers > Select your state > Answers@Anthem and select claims > Select Provider Appeal Policy and Procedure.

**COB**

**Coordination of Benefits (COB)** 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.

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 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.
**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.

**MEDICARE**

Anthem Medicare Supplement (MediGap) policies are secondary coverage when Medicare is primary coverage. The Medicare Part B intermediary 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). If the Medicare EOMB does not indicate the cross-over, providers should wait 30-45 days before submitting a secondary Claim to Anthem.

Anthem Medicare Advantage (MAPPO) policies include primary and secondary coverage combined into one policy. Providers submit these Claims to Anthem only.

Directions to Medicare information on the provider website: Go to [http://www.anthem.com/](http://www.anthem.com/); select VA; under Plans & Benefits; select Medicare Eligible; then scroll to links for VA information.

**OUT-OF-STATE BCBS MEDICAID MEMBERS**

At times, providers may render services to a patient with an out-of-state Medicaid plan (for example, in urgent or emergency situations). Medicaid is a state-run program, and requirements vary for each state, and thus each BCBS Plan. Some states require providers to enroll in their state Medicaid program in order to be reimbursed for claims for the out-of-state BCBS Medicaid member.

Claims should be submitted to Anthem in the same way you would submit a claim for any other out-of-state BCBS member.

If you are required to enroll in another state’s Medicaid program in order to be reimbursed, you should receive notification of this requirement when verifying eligibility and benefits for the member. Providers should enroll in the state’s Medicaid program before submitting a claim for an out-of-state BCBS Medicaid member to avoid delays in processing.

If a provider submits a claim for an out-of-state BCBS Medicaid member, and provider enrollment is required, the provider will receive a remittance with a denial. If the provider does not enroll in the member’s state Medicaid plan, the state law may require the member be held harmless.

To view provider enrollment requirements for each state, visit: [https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html](https://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html)
<table>
<thead>
<tr>
<th>OTHER GENERAL INFORMATION OF IMPORTANCE FOR ALL CLAIMS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEALTH CARE IDENTIFICATION NUMBER:</td>
</tr>
<tr>
<td>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>
</tbody>
</table>

| COLLECTING COST SHARES:                              |
| 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. |

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.

| RENDERING NOT MEDICALLY NECESSARY OR INVESTIGATIONAL/NON-COVERED SERVICES: |
| 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. |

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.

Without this signed statement, the Covered Individual is held harmless when Anthem denies the claim and the provider must write off the charge.

| NOTE: A generalized statement that the Covered Individual shall be responsible for any charges not covered by Anthem or health maintenance organization is not sufficient. |

<table>
<thead>
<tr>
<th>FEP AND MEDICARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA '93):</td>
</tr>
</tbody>
</table>
| As a result of the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) legislation, all FEHB fee-for-service carriers are required to price certain claims per the Medicare Part B equivalent amount. This legislative change became effective on January 1, 1995. OBRA '93 applies the Medicare Part B equivalent amount to claims for physicians’ services to retirees and annuitants enrolled in the Federal Employee Health Benefits (FEHB) Program who are 65 years of age and older and who do not participate in Medicare Part B. The Office of Personnel Management (OPM) has defined the individuals to whom the law applies as those who are enrolled in an FEHB Program and are annuitants or former spouses. In addition, the law also applies to family Members covered by a family enrollment of an annuitant or former spouse. The covered Member must:
  · Not be employed in a position which confers FEHBP coverage
  · Be age 65 or older
  · Not be covered by Medicare Part B. |
Preventable Adverse Events (‘‘PAE’’) Policy

Acute Care General Hospitals (Inpatient)

Three (3) Major Surgical Never Events

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

Whenever any of the events described in the grid below occur with respect to a Covered Individual, acute care general hospital is encouraged to report the PAE to the appropriate state agency, The Joint Commission (‘‘TJC’’), or a patient safety organization (‘‘PSO’’) certified and listed by the Agency for Healthcare Research and Quality.

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

CMS Hospital Acquired Conditions (‘‘HAC’’)

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

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

Providers and Facilities (excluding Inpatient Acute Care General Hospitals)

Four (4) Major Surgical Never Events

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

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

Coverage Guidelines

The Medical Policy & Technology Assessment Committee (“MPTAC”) is the authorizing body for coverage guidelines and clinical Utilization Management (“UM”) guidelines (collectively, "Coverage Guidelines"), which serve as a basis for coverage decisions. MPTAC is a multidisciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting memberships includes external physicians in clinical practices and participating in networks; external physicians in academic practices and participating in networks; and internal medical directors. Additional detail, including information about the MPTAC and its subcommittees is provided in ADMIN.00001 Medical Policy Formation.


Coverage Guideline and Clinical Utilization Management (UM) Guidelines Distinction

Coverage guidelines and clinical UM guidelines differ in the type of determination being made. In general, coverage guidelines address the Medical Necessity of new services and/or procedures and new applications of existing services and/or procedures, while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services. In addition, coverage guidelines are implemented by all Anthem Plans while clinical UM guidelines are adopted and implemented at the local Anthem Plan or line of business discretion.
Coverage and Clinical UM Guidelines are posted online at anthem.com

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

To locate medical policies or clinical UM guidelines online, go to anthem.com, select the Provider link in top center of the page. Select Virginia from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Coverage & Clinical UM Guideline, and Pre-Cert Requirements”. (Please note Coverage Guidelines and clinical UM guidelines are available for Local Plan members as well as BlueCard/Out-of-area members.)

Clinical UM Guidelines for Local Plan Members

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

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

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Utilization Management Program and Plan (the “Program”)

I. Introduction

Providers agree to abide by the following Utilization Management (“UM”) Program requirements in accordance with the terms of the Agreement and the Covered Individual’s Health Benefit Plan. Providers agree to cooperate with the Program in the development and implementation of action plans arising under these programs. Providers agree to adhere to the following provisions and provide the information as outlined.

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 the Plan may not be 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 (as defined below) 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 Program affords the following opportunities to Provider and Covered Individuals:

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

To the extent that any terms of this Program are in conflict with applicable laws or regulations, the laws/regulations shall control.

Contact Information:

Website – http://www.Anthem.com

Telephone Numbers:

1-800-533-1120  Anthem Blue Cross and Blue Shield, 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

Providers have access to Availity® and Point of Care for immediate access to the information and functionality needed to support utilization review. Refer to the Directory of Services section of this manual for more information about Availity® and Point of Care.

II. Definitions

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

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

2. Adverse Decision: An Anthem utilization review decision that a health care service rendered or proposed to be rendered was or is not Medically Necessary or is Investigational.

3. Attending Provider: 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.

4. Business Day: Monday through Friday, excluding designated company holidays.

5. Care Coordination: The activities conducted by Anthem clinical staff that occurs to evaluate any ongoing care gaps and help health care providers improve the inpatient care a Covered Individual receives.

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

7. Health Services Review: Anthem review that determines whether outpatient services are a Covered Service and are Medically Necessary.

8. Initial Request/Continued Stay Review (continuation of services): Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care.
and Discharge Planning.

9. Non-Covered Services: 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.

10. Notification: The telephonic and/or written/electronic communication to the applicable health care providers, facilities and the Covered Individuals of their rights if they disagree with Anthem’s utilization management (UM) decision.

11. Pre-Certification/Pre-authorization Requirements: List of procedures that require Pre-service Review by Anthem UM prior to service delivery.

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

13. Primary Care Physician: The physician who provides the primary health care services for a Covered Individual and coordinates other Covered Services when indicated.

14. Retrospective Review: Review for Medical Necessity that is conducted after services have been rendered to a Covered Individual. The review may occur before or after the claim is received.

15. Specialty Care Review: Primary Care Physician's recommendation for a patient to receive outpatient services from another in-network Provider.

16. The Program: Anthem or its designees who perform the utilization management services described in this document.

III. Overview

This document describes the Pre-service Review, Initial Request/Continued Stay Review, Care Coordination, Discharge Planning and Retrospective Review activities of Anthem (and its designees) with health care providers. Providers agree to participate in this Program as it may be amended, modified or updated periodically. 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.

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

Articles:
Article III. Overview
Article IV. General Information
Article V. Utilization Review Process
Article VI. Specialty Care Review
Article VII. Admission Review
Article VIII. Continued Stay Review, Discharge Planning, and Care Coordination
Article IX. Outpatient Health Services Review
Article X. Retrospective Review
Article XI. Drugs Requested through Medical Benefit
Article XII. Private Duty Nursing Review
Article XIII. Case Management
Article XIV. Behavioral Health Utilization Management
Article XV. Audit Activities
Article XVI. Program Responsibilities
Article XVII. Peer to Peer Process
Article XVIII. Reconsideration of Adverse Decisions
Article XIX. Program Appeals
IV. General Information

A. The Program applies to Medical Necessity or Investigational reviews 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.

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

C. 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 to have a particular service reviewed for Medically Necessity. 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.

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 non-Medically Necessary or Investigational Services 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. b. Specifically, if a Covered Individual receives 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. Any references made in this document to Program will include any review agents engaged by the Program to perform Medical Necessity, investigational or 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.

F. 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. See the applicable attachments for Documentation Guidelines:

a. Attachment A – Patient Medical Record Documentation Standards

b. Attachment B – Behavioral Health Documentation Standards

c. Attachment C - Guidelines for Skilled Nursing Care in the Home Setting

G. The Program will accept clinical information telephonically using the toll free number under the contact information, electronically, in writing and by facsimile. Photographs submitted as part of the Admission Review or Health Services Review process will not be returned to the Provider. CDs containing clinical will not be accepted.

H. 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 XV for additional details.

I. To ensure the patient receives the highest level of benefits or any benefit for Covered Individuals, Providers should refer patients to Participating Providers when medically appropriate. 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 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.

J. The Program 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.

K. The Provider must notify the Program in the event there is a quality of care incident that involves a Covered Individual.

V. Utilization Management Review Process

A. The Program provides a decision-making process that includes use of a physician consultant or medical director in any Medical Necessity or Investigational Adverse Decision. In the event that Medical Necessity cannot be established, the appeals process is available. See Article XIX 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. 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.

B. The following requirements apply to the following utilization review categories:

To initiate a utilization review, the Provider must supply the following information: (a) Covered Individual’s name, identification number and date of birth and (b) the health care provider’s or facility’s name, address and telephone number.
The following information is needed to substantiate the need for medical and behavioral health care services.

- Diagnosis
- Date of service
- Anticipated length of stay or duration of treatment
- Relevant Medical History
- Current Clinical Status
- Signs and or symptoms
- Lab/radiological results
- Patient response to prior and/or current treatment
- Treatment plan
- Discharge Needs

Additionally:

- For durable medical equipment reviews the Provider must provide: medical need for the equipment, current level of performance of ADL (Activities of Daily Living), anticipated goal that the equipment will provide, and
- For private duty nursing reviews the Provider must provide: description of the skilled nursing need(s), educational and treatment goals, current level of performing activities of daily living, educational and treatment goals, and caregiver involvement in care.

VI. Specialty Care Review

A. The Primary Care Physician on record is responsible for obtaining a Specialty Care Review for a Covered Individual to visit another in-network Provider when indicated by their clinical condition and if required by their Health Benefit Plan.

B. 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 the Program 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.

VII. Admission Review

A. The Attending Provider is responsible for ensuring that non-emergency Admission Review requirements are completed prior to services being rendered even if the facility requested the review as a courtesy to the Attending Provider. Pre-certification/Pre-authorization request should be submitted as soon as possible before the service occurs.

B. The Attending Provider must notify the Program at least three (3) Business Days in advance of an elective admission and prior to services being rendered. The request should occur during the Program’s normal business hours. 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.

C. The Attending Provider must request an Admission Review for emergency medical, surgical or behavioral health admissions by the end of the first business day following the admission or within 48 hours of the admission, whichever is later.

D. The Attending Provider must request an Admission Review for direct inpatient transfers made from one hospital to another. Procedures are the same as for any Admission Review request. If the transfer is approved, the Program will reimburse for ambulance transfer services.

E. Coverage for services for an HMO Covered Individual may be denied for failure to obtain an Admission Review except in the case of an Emergency. Coverage of services for a non-HMO Covered Individual may result in a partial or full denial of coverage if in retrospect, the service provided is determined not to be Medically Necessary. Sufficient clinical information must be provided to make a determination on whether a requested service is Medically Necessary.
VIII. 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.

B. 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.

C. 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 facility. This process may be coordinated with the facility.

D. Approval of benefits for continued hospitalization is subject to care continuing to be Medically Necessary.

E. If a Covered Individual is discharged 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.

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. It includes the coordination of medical services and supplies, medical personnel and family to facilitate the Covered Individuals timely discharge to a more appropriate level of care following an inpatient admission.

- The Attending Provider will work with the Program nurse reviewers to facilitate the discharge needs of the Covered Individual after inpatient care. 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 facility should obtain the appropriate review if a Covered Individual is discharge from inpatient care to a lower level of care. Discharge services may include but are not limited to: home health care including physical, speech and occupational therapies provided by a home health agency; private duty nursing; and skilled nursing facility or rehabilitation services.

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 appropriate level of care required by the medical condition, use health care benefits efficiently and effectively, and promote quality of care.

IX. Outpatient Health Services Review

A. The Provider is responsible for obtaining a Health Services Review during the Program’s normal business hours prior to the outpatient services being rendered except in Emergency situations. To allow time for decision-making, this request should be made as soon as possible and should be accompanied by relevant clinical information to substantiate the need for the requested services. This activity may be coordinated with the health care provider; however, failure to complete this process may result in partial or full denial of services.

B. The Provider is responsible for requesting additional services when needed prior to the end of the certified period. Approval of benefits is subject to care continuing to be Medically Necessary at the sole discretion of the Program.

C. The Provider is responsible for verifying whether continued services are required, and for supplying clinical 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 Provider’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.

D. Information should be submitted in conjunction with the ordering Provider and should include the Provider’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.

X. Retrospective Review

Retrospective utilization management is designed to review Admission Review and Health Services Review requests received after services have been delivered in accordance with the Covered Individual's Health Benefit Plan and Anthem coverage and clinical guidelines. Medical records and pertinent information regarding the Covered Individual's care may be reviewed by the Program’s health care professionals with review by peer clinical reviewers when necessary to determine the level of coverage, if any. This review may consider such factors as the Medical Necessity of services provided, whether the claim involves cosmetic or investigative procedures, or coverage for new technology treatment.

The Program’s medical management unit will conduct a Retrospective Review for requests received within 10 business days of the date the Covered Individual received the service. If the request for review is received 11 business days or more after the date of service, the Provider must submit the claim either electronically or on paper to the post-service claim review unit for adjudication. The claim will be reviewed prior to the claim adjudication. Some claims may be denied for lack of prior authorization pursuant to the provisions of your facility and/or professional contract.

XI. Drugs Requested Through Medical Benefits

A. 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 the Program’s website at http://www.anthem.com/ or by calling Medical Management at the number listed in the Contact Information in Article I.

B. The Attending Provider is responsible for providing the Program with appropriate clinical information for determining the Medical Necessity of the requested specialty drug. Furthermore, the Program will conduct an appropriateness review for drug infusions to ensure the requested infusion site is appropriate based on the category of drug and the Covered Individual’s medical condition. This applies to specialty drugs administered in the home setting, health care provider's office, infusion center or a facility. 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.

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.

XII. 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:

B. 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.

C. 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.

D. 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.

E. 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.

XIII. Case Management

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

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

XIV. Behavioral Health Utilization Management

Health Benefit Plans do not require a Health Services Review for outpatient psychiatric therapeutic procedures (CPT 90801-90899, and appropriate E&M codes), but may require Health Services Review for Transcranial Magnetic Stimulation (TMS) (CPT 90867-90869) and Applied Behavior Analysis (ABA) (CPT 0359T-0374T).

A. The Attending Provider shall obtain a Health Services Review for any TMS or ABA services. Health Services Review can be obtained during normal Program business hours.

B. TMS or ABA 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 TMS or ABA 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 TMS or ABA sessions. Any additional services must be certified and a treatment plan must be sent to the Program’s behavioral health department prior to services being rendered.

The Program uses behavioral health clinical guidelines and coverage guidelines 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 clinical guidelines are primarily symptom and behavior-based and were developed with input from behavioral health care practitioners, 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 Medical Policy & Technology Assessment Committee (MPATC). The latest version of the behavioral health clinical guidelines are 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 > select provider > select Answers@Anthem > select UM Review Requirements > select link to Anthem Coverage or Clinical UM Guideline (found in the center of the page).

XV. 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).

XVI. Program Responsibilities

The Program 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) when making Medical Necessity and other coverage determinations. Examples of such guidelines and/or literature that may be utilized or considered, in whole or in part, include, without limitation, MCG Care Guidelines * Guidelines, Anthem coverage or clinical 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 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.

A. 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.

B. Review staff includes 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.

C. All Medical Necessity Adverse Decision are made in the first instance by a medical director, physician consultant or for behavioral health, a doctoral-level clinical psychologist 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.

D. 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.

E. The Program will communicate its utilization review decision to the treating Provider no later than two Business Days after receipt by the Program of all information necessary to complete the review and will follow up in writing within two Business Days of the decision.* 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 Necessary or is Investigational. 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 I.

* The two-day time frame applies to fully-insured managed care health insurance plans. It is not applicable to self-funded health plans.

XVII. Peer to Peer Review Process

The Program uses a clinical peer-to-peer review process by which the Provider has the opportunity to offer more information regarding an Adverse Decision. This process allows the attending, treating or ordering physicians to request a peer-to-peer review to offer additional information and further discuss their cases with the Program’s peer clinical reviewers who made the initial Adverse Decision. Peer to peer reviews are available until such time as the appeal process has been exhausted.

Providers can initiate a peer-to-peer request if he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for which any Adverse Decision is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so. To schedule a peer to peer discussion, call the appropriate medical management number from the contact list.

XVIII. Reconsiderations of Adverse Decisions

Providers shall have the right to a reconsideration of an Adverse Decision. Only one reconsideration is allowed per Adverse Decision; however, the Provider still has the right to appeal. Any such reconsideration shall be subject to the following rules/requirements:
A. Reconsiderations shall be performed by an Anthem medical director or physician consultant, or a peer of the treating Provider other than the Anthem medical director or clinical peer that made the initial Adverse Decision.

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

C. The Provider must request a Reconsideration within 10 Business Days after the issuance of the initial Adverse Decision and prior to an appeal. Reconsiderations requested after 10 Business Days for the same service and the same date of service will be directed to follow the appeals process.

D. Reconsiderations are available for requests that are determined to be not Medically Necessary or Investigational. They are not available for services that are deemed to be non-covered per the contract; however, the Provider has the right to appeal contractual denials. See article XIX for information on requesting an appeal.

E. The Program shall notify the Provider verbally at the time of the reconsideration determination, and in writing following the reconsideration determination. If the reconsideration decision is upheld the Program will include the criteria used and the clinical reason for the Adverse Decision. In addition, the Provider will be informed of the process for filling an appeal with the contact name, address, and telephone number.

F. 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. Expedited reconsiderations are not available.

G. 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.

**XIX. 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

Attachment A

Patient Medical Record Documentation Standards

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.

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.

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. The CPT and diagnosis codes reported on the health insurance claim form should reflect the documentation in the medical record.

Documentation Guidelines:

- Each patient has an individual confidential medical record.
- Each page contains patient ID.
- Provider is identified on each entry.
- Medical record is legible.
- All entries are dated.
- Medical records are readily accessible during normal office hours.
- Specific allergies or drug reactions are documented prominently on the medical record.
- Documentation must reflect who rendered what service, why, when and to whom.
- A progress note is generated and documented after each patient contacted.

Provider Office Documentation Guidelines

For each patient medical record there is documentation of the following:

- Pertinent history and physical examination
- Personal and biographical data
- Current medications and therapies
- Completed problem list inclusive of recurrent or chronic illnesses or diseases
- Completed immunization records for children below age 16
- Periodic screening appropriate to patient age and conditions
- Appropriate health guidance/ counseling when indicated
- Physician review of consultant, lab and imaging studies
- Follow-up plan and/or return visit
- Written reports for diagnostic and therapeutic ancillary services
- Consultations with or referrals to other physicians and/or other Providers
- Concerns from previous visits are addressed

For each visit there is documentation of the following:

- Reason for visit and chief complaint
- Working diagnosis
- Treatment plan, including prescribed medications
- Patient education
Facility Documentation Guidelines

Patients receiving services in a hospital setting must be under the medical supervision of a physician. The physician maintains responsibility for total care of the patient. Signatures and credentials are required documentation. Although members of other disciplines write notes, the Provider has the responsibility of documenting the Medical Necessity for the prescribed care.

A. All hospital services rendered must be appropriately documented in the patient'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:

- Describe the patient's clinical signs and symptoms (including specific examples) that necessitate admission including failed response to outpatient management.
- Document an accurate and complete chronological picture of the patient's clinical course with accessibility to past and present diagnoses, and relevant health risk factors.
- Support the intensity of the patient's evaluation and/or treatment, including Provider's thought processes and the complexity of medical decision-making.
- Document the implementation of a treatment and discharge plan specifically designed for the patient, detailing frequency and type of treatment/medication and dosage; any referrals/consultations, and patient/family education follow up needs.
- Document patient's progress, including response to treatment, change in treatment, change in diagnosis/condition, and Patient’s non-compliance (if relevant).
- Document continuous skilled observation and intervention by trained personnel consultants.
- Document reasons for and results of x-rays, lab tests, invasive procedures, and other ancillary services.
- Document extenuating circumstances that necessitate short periods (less than 3 hours) of absence from the Hospital (i.e., court appearance, medical/surgical treatment).
- All entries to the medical records should be dated and authenticated.

B. All professional Provider services must adhere to the following guidelines:
- Documentation in the medical record must verify each individual charge submitted to Anthem.
- 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.
- 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

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. Evaluations, assessments, and other services shall be made by credentialed and/or licensed professional staff according to hospital policy and professional standards. Although members of other disciplines write psychotherapy notes, the physician of record is responsible for documenting the Medical Necessity for the prescribed psychotherapy and the total treatment program. Signatures and credentials are required documentation for the Attending or treating Provider all licensed staff.

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.

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. The determination of reimbursement requires adequate documentation of patient acuity and services provided. The Provider must maintain accurate and accurate clinical records.

Inpatient Documentation Guidelines

I. Admission Note

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.

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

B. The patient's potential for danger to self, others and/or property must be clearly documented. Documentation must indicate the following:
   - Presenting thoughts
   - Intent
   - Plan
   - Method

C. An initial diagnostic evaluation must be documented and include the following:
   - Date of exam
   - Diagnosis
   - History of present illness
   - Mental status exam
   - Presenting problem – supporting signs and symptoms
   - Medical history, including medications & allergies
   - History of alcohol and drug use
   - Social history /family history
   - Previous treatment and outcome

D. Initial treatment plan must be documented, providing the following information:
   - Goals for hospitalization
   - Estimated Length of Stay (LOS)
   - Initial Discharge Plan
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:

- General appearance and nutritional status
- Skin and lymph
- Head and neck
- Eyes/vision
- Ears/hearing
- Nose, mouth and throat
- Breast
- Neurological, including:
  - Motor
  - Sensory
  - Cranial nerves
  - Deep tendon reflexes
  - Strength
  - Cerebrum
  - Posture, gait
- Chest and lungs
- Heart
- Abdomen
- Genitalia
- Rectal
- Bones, joints and muscles
- Clinical impression including activity Level

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

- Interventions, goals of the master treatment plan and coordination of services must be substantiated.
- An explanation of positive or negative change in the patient's condition is required.
- Deterioration or complication following initiation or change of medication must be documented.
- Ongoing documentation of the patient's mental, functional and medical stress is required.
- Patient’s response to treatment must be documented
- 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:
   - Date of service
   - Length of session
   - Statement of therapeutic focus, including the therapist's intervention(s)
   - Periodic reference to the patient's progress
   - Individuals present at the session
   - 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

Behavioral Health 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:
   - history of present illness
   - evidence of personal distress
   - impairment of functioning
II. 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

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:

- Patient’s name
- Focus of session, including the therapist’s intervention(s)
- Date of service
- Future directions including revisions in goals, if indicated
- Type and length of session
- Next scheduled appointment
- Individuals present at the session
- Summary of treatment outcome upon termination
- Current symptoms
- A separate note is written in the medical record for each patient in group therapy, indicating the nature of the participation at each session.
- Current level of functioning
- 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:

- Cerebrovascular accident (CVA) with severe hemiparesis.
- Severe chronic obstructive pulmonary disease (COPD) with shortness of breath (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-operative 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 accuchek/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.(Activities of Daily Living)
• Socio-economic factors do not determine whether care is skilled.
• Homemaker services
• Custodial Care
Credentialing

Credentialing and Recredentialing
Program Description

Definitions

AAPSE: Accreditation Association for Podiatric Surgical Facilities
AAAHC: Accreditation Association for Ambulatory Health Care
AAAASF: American Association for Accreditation of Ambulatory Surgery Facilities
AASM: American Academy of Sleep Medicine
ABC: American Board for Certification in Orthotics, Prosthetics & Pedorthics
ABCN: American Board of Clinical Neuropsychology
ABMS: American Board of Medical Specialties
ABN: American Board of Professional Neuropsychology
ABPP: American Board of Professional Psychology
ACHC: Accreditation Commission for Health Care
ACR: American College of Radiology
AIUM: American Institute of Ultrasound in Medicine, Ultrasound Practice Accreditation Council

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

Enterprise: refers to Anthem, Inc., and its Affiliates.

Anthem: 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.

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

AOA: American Osteopathic Association
APA: American Psychological Association

Attestation: A signed statement indicating that a Practitioner or HDO designate 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.

BOC INTL: The Board of Certification/Accreditation
CACREP: Council for Accreditation of Counseling and Related Educational Programs
CABC: Commission for the Accreditation of Birth Centers
CAHC: Commission on Accreditation for Home Care, Inc. (New Jersey Specific)
CAP: College of American Pathologists
CARF: Commission on Accreditation of Rehabilitation Facilities

CASWE: Canadian Association for Social Work Education

CCAC: CARF Continuing Care Accreditation Commission

Certification review: verification of criteria required for practice, training, and/or delivery of clinical services, including but not limited to licensure, and/or compliance with regulatory requirements and/or state or federal contract requirements for provision of such services.

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

CIHQ: Center for Improvement in Healthcare Quality

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.

COA: Council on Accreditation

COLA: Commission on Office Laboratory Accreditation

COAMFTE: Committee on Accreditation for Marriage and Family Therapy Education

Cteam: The Compliance Team

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

DNV NIAHO: Det Norske Veritas (DNV) Healthcare, Inc. NIAHO Hospital Accreditation Program

FDA: Food and Drug Administration

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.

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

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

HQAA: Healthcare Quality Association on Accreditation

IAC: Intersocietal Accreditation Commission (CMS approved to handle MIPPA accreditation)

Immediate Termination: A termination of network participation which is effective immediately. It occurs prior to review by the geographic Credentials Committee, and prior to the Provider being allowed an appeal, if applicable. It is used when determined necessary by Anthem to protect against imminent danger to the health or welfare of Anthem’s covered individuals or a Provider has been sanctioned, debared or excluded from the Medicare, Medicaid or FEHB programs.

○ Termination due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB programs do not go to the geographic Credentials Committee for review are not eligible for Informal Review/Reconsideration or Formal Appeal (see Credentialing Policies #13 and 14). Note: Special consideration regarding the Provider’s continued participation in Anthem’s other credentialled practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the Provider is important for network adequacy. The request with supporting information will be brought to
Anthem’s geographic Credentials Committee for consideration and final determination, without Provider appeal rights related to the special consideration, regarding the Provider’s continued participation in Anthem’s other credentialed provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.

**IMO:** 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.

**NAPB:** National Association of Boards of Pharmacy (DMEPOS)

**NBAOS:** National Board of Accreditation for Orthotic Suppliers

**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 and which has credentialed by and has entered into an agreement with Anthem to provide health care services to Company’s 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 or certified (as applicable) in accordance with all applicable state and federal laws to deliver health care services.

**Professional conduct and competence review:** Peer review by the geographic Credentialing Committee that assesses a Provider’s conduct and qualifications in accordance with Anthem Credentialing Policies.

**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 licensed or certified (as applicable) person or institution that provides health care services, including practitioners and HDOs.

**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

**UCAOA:** Urgent Care Association of America
Policy 1 Credentialing Program Structure

i. The National Credentials Committee (NCC) establishes the policies and procedures for:
   a. Credentialing, re-credentialing, ongoing monitoring and oversight of network practitioners and HDOs; and
   b. The delegation of credentialing related activities; and
   c. Appeals of adverse credentialing decisions; and
   d. Review of Company clinical staff qualifications and approval for those staff to perform clinical functions on behalf of Anthem.

ii. The NCC policies will:
   a. Comply with relevant federal law; and
   b. Meet standards set by relevant regulatory and accrediting bodies; and
   c. Be modified for state specific use to comply with state law where applicable; and
   d. Be reviewed at least annually, and revised as necessary.

iii. The NCC is:
   a. Composed of ten to twelve Company medical directors selected to represent various clinical and business areas of Anthem; representation shall include the following:
      • At least two medical directors representing Commercial and Medicaid lines of business, respectively, and one medical director representing Medicare line of business; and
      • At least one medical director representing behavioral health; and
      • At least two medical directors who act as chairs/vice-chairs of geographic Company Credentials Committees (as detailed in Credentialing Policy #3); and
   b. Chaired by a Company medical director as designated by the Vice President (VP) responsible for Enterprise Credentialing Policy. The VP responsible for Enterprise Credentialing Policy reports to Anthem Chief Medical Officer.

iv. Anthem shall:
   a. Maintain an appropriate staff to implement credentialing policy; and
   b. Establish a geographic Company Credentials Committee (CC) (as detailed in Credentialing Policy #3) to perform credentialing review of practitioners and HDOs and render determinations; and
   c. Review and provide input on the policies established by the NCC; and
   d. Adopt and implement the policies and procedures set forth by the NCC.

Anthem establishes a local credentialing and peer review body known as the geographic Credentials Committee (CC). The CC is authorized by the NCC to evaluate and determine eligibility for practitioners and HDOs to participate in Anthem’s credentialed provider network(s) and be listed in Anthem’s provider directories. The CC’s functions are governed by Enterprise Anthem Credentialing Policy, and are supported by Anthem credentials staff (see credentialing Policy #3).

Policy 2 Credentialing Program Scope

Professional Practitioners:

a. Practitioner Types: Anthem credentials the following types of contracted healthcare Practitioners, when an independent relationship exists between Anthem and the Practitioner, or the individual Practitioner is listed individually in Anthem’s provider network directory; and exclusions in section b(2) (see below) do not apply:
   • Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO);
   • Doctors of Podiatry;
   • Chiropractors;
   • Optometrists providing services covered under the medical benefits plan;
   • Oral and Maxillofacial Surgeons;
   • Psychologists who are state certified or licensed and have doctoral or master’s level training;
   • Clinical social workers who are state certified or state licensed and have master’s level training;
   • Psychiatric nurse practitioners who are nationally or state certified or state licensed or behavioral nurse specialists with master’s level training;
• Other behavioral health care specialists who are licensed, certified or registered by the state to practice independently;
• Telemedicine practitioners who have an independent relationship with Anthem and who provide treatment services under Anthem’s medical benefit;
• Medical therapists, e.g., physical therapists, speech therapists, and occupational therapists;
• Licensed Genetic Counselors who are licensed by the state to practice independently;
• Audiologists who are licensed by the state to practice independently;
• Acupuncturists (non-MD/DO) who are licensed, certified or registered by the state to practice independently;
• Nurse practitioners, certified nurse midwives and physician assistants;
• Registered Dieticians (Medicaid markets and Medicare Advantage markets).

b. Practitioners with whom we have a contractual relationship do not require credentialing when the Practitioner:
• Practices exclusively in an inpatient setting and provides care for Company covered Individuals only because covered Individuals are directed to the hospital or another inpatient setting; OR
• Practices exclusively in free-standing facilities and provides care for Company covered Individuals only because covered Individuals are directed to the facility. Examples of this type of Practitioner include, but are not limited to:
  • Pathologists
  • Radiologists
  • Anesthesiologists
  • Neonatologists
  • Emergency Room Physicians
  • Urgent Care Center Physicians
  • Urgent Care Center mid-level providers (e.g. nurse practitioners, physician assistants)
  • Hospitalists
  • Pediatric Intensive Care Specialists
  • Other Intensive Care Specialists

c. The following behavioral health Practitioner types are not subject to professional conduct and competence review under Company’s credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services:
• Certified Behavioral Analysts;
• Certified Addiction Counselors;
• Substance Abuse Practitioners.

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

Healthcare Delivery Organizations (HDOs):

a. Anthem credentials the following types of HDOs:
• Hospitals;
• Home Health Agencies;
• Skilled Nursing Facilities (Nursing Homes);
• Free-standing Surgical Centers;
• Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory settings:
  i. Adult Family Care/Foster Care Homes;
  ii. Ambulatory Detox;
  iii. Community Mental Health Centers (CMHC);
  iv. Crisis Stabilization Units;
  v. Intensive Family Intervention Services;
  vi. Intensive Outpatient – Mental Health and/or Substance Abuse;
  vii. Methadone Maintenance Clinics;
  viii. Outpatient Mental Health Clinics;
  ix. Outpatient Substance Abuse Clinics;
  x. Partial Hospitalization – Mental Health and/or Substance Abuse;
xi. Residential Treatment Centers (RTC) – Psychiatric and/or Substance Abuse;
   • Birthing Centers;
   • Convenient Care Centers/Retail Health Clinics/Walk-In Clinics;
   • Intermediate Care Facilities;
   • Urgent Care Centers;
   • Federally Qualified Health Centers (FQHC);
   • Home Infusion Therapy;
   • Rural Health Clinics;

b. The following Health Delivery Organizations are not subject to professional conduct and competence review under Company’s credentialing program, but are subject to a certification requirement process:
   • Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
   • End Stage Renal Disease (ESRD) service providers (dialysis facilities)
   • Hospices
   • Portable x-ray Suppliers

**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/vice 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 - Practitioners

Each health care Practitioner applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of Anthem’s programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Practitioners within scope of credentialing policy are listed in Credentialing Policy #2. The NCC determines the Practitioner types defined within scope of Anthem’s credentialing program, as established by, but not limited to: perceived risk to covered Individualship and volume of services rendered.

Note: Additional practitioner types, when explicitly required by specific regulatory or contractual obligations, may be reviewed according to contractual requirements and/or local, state, and federal regulations; however, such review lies outside the scope of this Credentialing Policy #4.0.

Health Care Practitioners

Eligibility Criteria Not Subject to Committee Review – all health care Practitioners within the scope of Anthem’s Credentialing Program applying for participation in Anthem’s programs or provider network(s) must meet the following criteria in order to be considered for participation. Applicants for initial participation in Anthem’s programs or provider network(s) who do not meet the criteria below will be notified of this failure to meet criteria and their applications will not proceed through the credentialing process.

- Must not be currently sanctioned, debarred or excluded from participation in any of the following programs, Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHBP). Note: If, once a Practitioner participates in Anthem’s programs or provider network(s), Federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem’s other credentialed provider network(s). Special consideration regarding the Practitioner’s continued participation in Anthem’s other credentialed practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the Practitioner is important for network adequacy. The request with supporting information will be brought to Anthem’s geographic Credentials Committee for consideration and final determination, without Practitioner appeal rights related to the special consideration, regarding the Practitioner’s continued participation in Anthem’s other credentialed provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.
- Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Anthem’s covered Individuals; unless an exception to this requirement applies (see below).
- Possess a current, valid, and unrestricted DEA or CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Anthem’s covered Individuals (see list below for Practitioner types who do not require a DEA or CDS); unless an exception to this requirement applies. 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.

a. Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee – all health care Practitioners within the scope of Anthem’s Credentialing Program applying for participation in Anthem’s programs or provider network(s) should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the geographic Credentials Committee (CC). If an applicant for initial participation or continued participation in Anthem’s programs or provider network(s) 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 pursuant to Credentialing Policy.
- Exception to state license requirements may be made in the following instances:
  i. For those applicants not previously participating in Anthem’s provider network(s) 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, as detailed in Credentialing Policy #16. These applicants will be subject to review per Credentialing Policy.
  ii. For applicants previously terminated from Anthem’s provider network(s) related to licensure action for substance abuse per Credentialing Policy #16, 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. These applicants will be subject to review per Credentialing Policy.
  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 time-frame in which a permanent license is required. These will be viewed as Level I files and will not require Credentials Committee review. Anthem will view any encumbrances, probations or other restrictive actions 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. These will be viewed as Level I (See Credentialing Policy #8) files and will not require Credentials Committee review. Anthem will view any encumbrances, probations or other restrictive actions taken against such an applicant as not meeting criteria.
  v. Indian Health Services (HIS) Practitioners who provide services in states which recognize HIS licensure as a proxy for the Practitioner’s state licensure do not require a same state license. The HIS license will be verified and documentation showing state acceptance of the HIS license will be recorded.

- Exception to DEA or CDS registration requirements may be made in the following instances: (NOTE: For Practitioner types who do not require a DEA or CDS registration see below. In the event that any of these Practitioners do have a DEA or CDS registration, it will be subject to verification).
  i. Initial applicants who have no DEA/CDS registration: 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:
     1. It can be verified that the applicant's application is pending; and
     2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
     3. The applicant agrees to notify Anthem upon receipt of the required DEA; and
     4. Anthem will verify the appropriate DEA/CDS via standard sources; and
     5. The applicant agrees that failure to provide the appropriate DEA registration 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, unless the practitioner is delivering services in a telemedicine environment only and does not require
a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law (see Attachment B). If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:

1. It can be verified that the applicant’s application is pending; and
2. The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
3. The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
4. Anthem will verify the appropriate DEA/CDS registration via standard sources; and
5. The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.

Practitioners Types and Physician Specialties Not Requiring DEA and CDS Registration

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. Nurse Practitioners
5. Physician’s Assistants
6. Medical Genetics
7. Medical Therapists, e.g. physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
8. Practitioners who deliver services in a telemedicine environment are required to have a DEA/CDS registration in their primary location, but are not required to hold additional DEA/CDS registration to perform telemedicine services in additional locations where they are actively licensed to practice, unless DEA/CDS registration is required under federal or state law.
9. For continued participation of assistant surgeons upon re-credentialing, if that physician certifies that he/she: (1) will deliver services to Anthem’s covered Individuals in an assistant surgeon capacity only; and (2) has let his or her DEA registration voluntarily lapse because controlled substances requiring a DEA registration are not prescribed within the limited scope of that assistant surgeon’s practice. However, re-credentialing is not allowed if the assistant surgeon’s DEA registration is or was suspended, revoked, or surrendered for other reasons.
10. Radiologists practicing in an office setting
11. Pathologists practicing in an office setting
12. Licensed Genetic Counselors
13. Audiologists
14. Acupuncturists (non-MD/DO)

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.

Note: providers meeting one of the alternative criteria specified above will be viewed as meeting all Company education, training and certification criteria and will not be required to undergo additional review or individual presentation to the geographic Credentials Committee.

iv. The individual is seeking provider specialty designation listing as a General Practitioner and meets the criteria outlined in (1) and (2) and (3) below:
   1. Meets both of the following criteria:
      a. 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; AND
      b. A minimum of 10 years of clinical practice experience; AND
      2. Meets one of the following criteria for network inclusion of a General Practitioner:
         i. Demonstrates significant access need or extenuating or special circumstances that warrant consideration; i.e. applicant has unique skills not otherwise available in network, e.g. procedural, special language skills, or there is a need for this specialty in this geographic area for access reasons: rural location and/or underserved population not served by other practitioners; AND
         3. Meets level II committee review, including all credentialing criteria and processes outlined in Credentialing Policies.

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 with board certification from the American Board of Podiatric Medicine will be granted five years after the completion of their residency to meet this requirement. Individuals with board certification from the American Board of Foot and Ankle Surgery will be granted seven years after completion of their residency to meet this requirement. 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 CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. 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, recredentialing or ongoing monitoring 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.

iv. No history of disciplinary actions or sanctions, against the applicant's license or sanctions against the applicant's license, DEA and/or CDS registration, or any 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, re-credentialing and ongoing monitoring process. For applicants with current actions or sanctions, see e.1.a above.

v. 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, re-credentialing or ongoing monitoring process.

xiii. 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.

xiv. 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.

Policy 4.0.1 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 Credentialing Policy #4.0 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, re-credentialing and ongoing monitoring 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. Provider Type Eligibility Criteria – Education and Training (by provider type)

1. LICENSED CLINICAL SOCIAL WORKERS (LCSW) or other masters level social work license type as defined in Attachment A below.
   • 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 or accredited by the Canadian Association for Social Work Education, CASWE. 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 a Masters level degree does not meet criteria and the Provider obtained PhD training as a clinical psychologist, but is not licensed as such, the Practitioner can be reviewed. To meet credentialing 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.
   • 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.
   • 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.
   • 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

- 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

- 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.

- 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.

5. CLINICAL NEUROPSYCHOLOGIST

- Standard Criteria – Candidates must meet all the criteria for a clinical psychologist listed in section 4 above and be Board certified by either the American Board of Professional Neuropsychology (ABN) or American Board of Clinical Neuropsychology (ABCN) or in the absence of such certification does not raise a reasonable suspicion of future substandard conduct or competence.

- Alternative Criteria – Alternatively, a Provider credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered, subject to review by the CC.

- Other Criteria – Clinical neuropsychologists who are neither board certified nor listed in the National Register will require individual CC review. These Providers must have appropriate training and/or experience in neuropsychology as evidence by one or more of the following:
  
  i. Training:

     1. Transcript of applicable pre-doctoral training; or
     2. Documentation of applicable formal 1 year post-doctoral training. (Participation in CEU training alone would not be considered adequate); or
     3. Letters from supervisors in clinical neuropsychology (including number of hours per week.

  ii. Experience:

     1. Minimum of 5 years’ experience practicing neuropsychology at least 10 hours per week.

6. LICENSED PSYCHOANALYSTS

- Applies only to Practitioners in states that license psychoanalysts.
- Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
- Practitioner must possess a valid psychoanalysis state license.
  
  i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 5 years of the time the Practitioner graduates.
  
  ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting
agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.

1. A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.

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

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

ATTACHMENT A

Licensures Which Meet Criteria

<table>
<thead>
<tr>
<th>State</th>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>VA</td>
<td>PSY</td>
<td>Licensed Clinical Psychologist</td>
</tr>
<tr>
<td></td>
<td>LCSW</td>
<td>Licensed Clinical Social Worker</td>
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<tr>
<td></td>
<td>LMFT</td>
<td>Licensed Marriage &amp; Family Therapist</td>
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<tr>
<td></td>
<td>LPC</td>
<td>Licensed Professional Counselor</td>
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<tr>
<td></td>
<td>CNS</td>
<td>Clinical Nurse Specialist</td>
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</tbody>
</table>

Policy 4.0.2 Credentialing of Nurse Practitioners, Certified Nurse Midwives and Physician’s Assistants

The purpose of this policy is to address the credentialing of NPs, CNMs and PAs when an independent relationship exists between Anthem and the Practitioner, and such individual Practitioner is listed individually in the network directory.

General Criteria and Process:
Anthem has identified and developed minimum acceptable criteria for all Practitioners who fall within the scope of its credentialing program. This Credentialing policy specifically addresses only the education and training requirements of Nurse Practitioners (NPs), Certified Nurse Midwives (CNMs) and Physician Assistants (PAs). All relevant requirements detailed in Credentialing Policy #4.0 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 company, 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. Also, all requirements for primary source verification outlined in Credentialing Policy are to be enforced. These include license, DEA (if applicable), education (if not performed by the state licensing body) and procurement of an NPDB report.

Ongoing Monitoring:
Midlevel Practitioners added to the network will be subjected to the ongoing monitoring processes outlined in Credentialing Policy #12 and will be re-credentialed every three years as described in Credentialing Policy #9. The credentialing and re-credentialing process will occur as described in Credentialing Policies #4, through #9.

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

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], or
   b. American Academy of Nurse Practitioners Certification Program (www.aanp certification.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/pstore/control/exams/ac/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 C I H Q, 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 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 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 CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.

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 CIHQ, TJIC, 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.
Policy 4.1 Professional Competence and Conduct Criteria – Health Delivery Organizations

i. Health Delivery Organizations (HDO’s) that participate in Anthem’s provider network(s) and are within the scope of the credentialing program must meet appropriate standards of professional conduct and competence as reviewed and determined by Anthem’s National Credentials Committee (NCC). HDOs within scope of credentialing policy are listed in Credentialing Policy #2.

ii. Each HDO applying for initial credentialing or re-credentialing must satisfy the applicable eligibility criteria regarding professional conduct and competence to participate in one or more of Anthem’s programs or provider network(s). Eligibility criteria can be separated into two categories: (1) criteria not subject to committee review (must be met); and (2) criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee. The latter must be reviewed and approved by the geographic Credentials Committee (CC). Required elements and other eligibility criteria for HDO’s are described in detail in “Procedures” (below).

iii. The NCC determines the HDO types defined within scope of Anthem’s program, as established by, but not limited to: perceived risk to membership and volume of services rendered.

   i. Eligibility Criteria Not Subject to Committee Review – all HDOs within the scope of Anthem Credentialing program applying for initial or continued participation in Anthem’s programs or provider network(s) must meet the following criteria in order to be considered for participation:

   - 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. Note: If, once an HDO participates in Anthem’s programs or provider network(s), a HDO’s license become non-current, invalid, encumbered, restricted, or probationary, at the time of identification, information will be brought to Anthem’s peer review committee for consideration regarding the HDO’s continued participation in Anthem’s credentialed network.
   
   - Must not be currently sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the Federal Employees Health Benefits Program (FEHB). Note: If, once an HDO participates in Anthem’s programs or provider network(s), exclusion from Medicare, Medicaid or FEHB occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider network(s) as well as Anthem’s other credentialed provider network(s). Special consideration regarding the HDO’s continued participation in Anthem’s other credentialed practitioner network(s) may be requested by the Vice President (VP) responsible for that network(s) if, in the opinion of the requesting VP, the following criteria are met: the sanction, debarment or exclusion is not reflective of significant issues of professional conduct and competence, and participation of the HDO is important for network adequacy. The request with supporting information will be brought to Anthem’s geographic Credentials Committee for consideration and final determination, without HDO appeal rights related to the special consideration, regarding the HDO’s continued participation in Anthem’s other credentialed provider network(s), if such participation would be permitted under applicable State regulation, rule or contract requirements.

   - Must be in good standing with any other applicable state or federal regulatory body as defined in Credentialing Policy.

   ii. Criteria subject to appropriate standards of professional conduct and competence as reviewed and determined by a peer committee – all HDOs within the scope of Anthem’s Credentialing Program applying for initial or continued participation in Anthem’s programs or provider network(s) should meet the following criteria in order to be considered for participation, with exceptions reviewed and approved by the geographic Credentials Committee (CC):

   Note: 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 pursuant to Credentialing Policies #8, and 9. This will be regarded as a Level II review if performed during credentialing or re-credentialing, or an Off Cycle, Level III review if information is received and reviewed between the normal re-credentialing cycle (see Credentialing Policy #12).

   - Application and supporting documentation must not contain any material omissions or falsifications, including any additional information requested by Anthem.
• Complaints received from covered Individuals and/or other providers may be reviewed for compliance with Company standards.
• Performance indicators obtained during the credentialing, re-credentialing or ongoing monitoring process, if applicable, must meet Company standards.
• 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 facility.
• Any history of disciplinary actions or investigations, including termination, warnings, or notices of potential poor performance related to the HDO’s license or accreditation must be reviewed and 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, re-credentialing or sanction monitoring process. For HDOs with current actions or sanctions, see Section e.1.b above.
• Acceptable accreditation from a recognized entity exists (see Attachment A), or in the absence of this accreditation meets the following criteria:
  i. Must have an access needs waiver submitted on their behalf and meet the following criteria:
    1. Be confirmed to be delivering services in a designated rural area (based on US Census Bureau); or
    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
       a. Have no deficiencies noted on Medicare or state oversight review which would adversely affect quality of care or patient safety (see Attachment B for SNFs: scope and severity of identified deficiencies cannot be rated “E, F, G, H, I, J, K or L.”); and
       b. Have the Medicare or state agency survey approved after individual review to validate compliance with company standards by the Credentials Committee; or
  3. Undergo or have undergone within the prior 36 months a site visit survey and receive a passing score by a designated independent external entity (DIEE) using that external entity’s previously established and NCC approved criteria.
iii. Other Exceptions – In situations where a HDO does not meet initial credentialing criteria or the exceptions noted above, the State President may request an exception due to significant access need or extenuating or special circumstances that warrant special consideration. In order to request this exception, the geographic CC must first review the exception request and if, after further consideration, votes by a majority of the CC that there are special circumstances that warrant a possible exception, the request for an exception will be brought to the NCC along with any supporting information for consideration and final determination. The NCC may grant a time-specific conditional waiver (e.g. 3 months) for satisfying the initial credentialing criteria at issue, or may grant a full exception to the specific failed credentialing criteria as it relates to the credentialing of that HDO; provided, that if a full exception is granted, that HDO will still be subject to the re-credentialing process. Applicants who are granted a time-specific conditional waiver for initial participation will be re-presented to the NCC for determination at the end of the time-conditional waiver. However, repeat presentation to the NCC will not be required if the need for an exception for failure to meet criteria no longer exists. If, upon re-credentialing, that HDO fails to meet re-credentialing criteria, a request for an exception must be re-initiated. The HDO and the geographic CC will be notified of the final NCC determination; these determinations are not eligible for further reconsideration or appeal under Credentialing Policy. Note: Exceptions will not be granted for an incomplete credentialing application, failure to submit required supporting documentation, or any actions for which state or Federal rules, regulations or requirements do not allow participation in those programs. Exceptions to any accreditation or site visit survey requirements will not be granted for initial or re-credentialing. In addition, any exception that may be made under this section will not modify the requirements for reviews and determinations triggered by off-cycle issues which are identified through Company’s continuous monitoring processes. This process is not intended for exceptions to business participation requirements such as dollar thresholds for malpractice insurance.
iv. Initial HDO Credentialing Process and Standards
1. New HDO applicants submit a standardized application to Anthem for review.
2. Applicants who meet Company initial eligibility criteria will undergo professional conduct and competence review.
3. As part of eligibility criteria accreditation appropriate for HDO type should be verified per Attachment A below.
4. Accredited HDO’s or Medicare certified SNFs meeting all criteria will be viewed as Level I providers and may be approved by the chair/vice-chair of the CC or medical director designee (See Credentialing Policies #3, #8).

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

### A. Medical Facilities

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

### B. Behavioral Health

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

<table>
<thead>
<tr>
<th>Facility Type (Behavioral Health Care)</th>
<th>Acceptable Accrediting Agencies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Inpatient Hospital - Detoxification Only Facilities</td>
<td>DNV/NIAHO, HFAP, TJC, CTEAM</td>
</tr>
<tr>
<td>Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation</td>
<td>TJC, NIAHO, CTEAM</td>
</tr>
<tr>
<td>Behavioral Health Ambulatory Detox</td>
<td>TJC, CARF</td>
</tr>
<tr>
<td>Outpatient Substance Abuse Clinics</td>
<td>TJC, CARF, COA</td>
</tr>
<tr>
<td>Methadone Maintenance Clinic</td>
<td>TJC, CARF</td>
</tr>
</tbody>
</table>

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.

- Faxed, digital, electronic, scanned or photocopied signatures are acceptable. Signature stamps are not acceptable unless the Practitioner is physically impaired. The organization must document the disability in the Practitioner's file if the Practitioner uses a signature stamp. Pencils are not an acceptable writing instrument for credentialing documentation. Written documentation must be non-erasable ink.
- The application materials sent by Anthem include, at a minimum the following:
  - Cover letter or other explanatory information;
  - Credentialing application; and
  - Attestation form
- 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.
- 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.
- Responses received from Practitioners to requests for clarification will be documented in the credentials file. Oversight of this process for additional information or clarification will be the responsibility of the manager of the credentialing unit.
- 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.
- 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.

- In completing the application, each applicant must disclose the existence of, and provide explanations for, the following:
  - 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;
  - 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;
  - 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;
  - 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;
  - 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;
  - 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;
  - Instances in which the Practitioner has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware that an investigation is pending that may lead to such action;
  - 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;
  - Physical or mental health reasons which would limit the Practitioner’s ability to provide services to a patient;
  - Additional information requested by Anthem to explain or provide details regarding responses obtained on the credentialing application.

- All Practitioners must sign and date an attestation statement that includes, but is not limited to:
  - Reasons for any inability to perform the essential functions of the position, with or without accommodation;
  - Lack of present illegal drug use;
  - History of licensing board action or felony convictions;
  - History of loss or limitation of privileges or disciplinary activity;
  - Current malpractice insurance coverage;
  - The correctness and completeness of the application;
  - Permission to release information as needed to complete the credentialing process.

- Each Practitioner must submit, along with the application, at a minimum the following:
  - Curriculum vitae, resume or work history if work history is not included on the application.

- The file will go through a thorough review before it is presented to the Credentials Committee to assess completeness in data. All of the required information must be current when presented to the geographic Credentials Committee (CC) and must be verified within the 180 day period prior to the CC making its credentialing recommendations or as otherwise required by applicable accreditation standards.

- Health Delivery Organizations (HDO):
  - Each HDO applying for initial participation in Anthem’s programs or provider network(s) must complete and submit Anthem’s applicable credentialing application along with all required supporting documentation.
  - The application materials sent by Anthem include, at a minimum the following:
    - Cover letter or other explanatory information;
    - Credentialing application;
    - Attestation form.
• In completing the application, each HDO must disclose the existence of, and provide explanations for, the following:
  • 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;
  • 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;
  • 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;
  • Instances in which the facility has been sanctioned or debarred from Medicare, Medicaid or FEHB programs or is aware of a pending investigation that may lead to such action;
  • 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.
• All HDO applications must include a signed and dated attestation statement that includes, but is not limited to:
  • History of loss of license and felony convictions;
  • Current malpractice insurance coverage; and
  • The correctness and completeness of the application.
• Each HDO must submit, along with the application, at a minimum the following:
  • Medicare certification, if applicable;
  • Recognized accrediting organization certification or Medicare or state site survey results.
• Upon request, HDO’s will be provided with the status of its credentialing application.
• Anthem may request and shall accept additional information from the HDO to correct or explain incomplete, inaccurate, or conflicting credentialing information. The CC 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.
• 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.
• The file will go through a review before it is presented to the Credentials Committee to ensure completeness in data. All of the required information must be current when presented to the CC and must be verified within the 180 day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.
• Non-discrimination Policy:
  • Anthem will not discriminate against any applicant for participation in its programs or provider network(s) 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. Anthem will audit credentialing files annually to identify discriminatory practices in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.
• Review and Determination:
  • All applications for initial participation in Anthem’s programs or provider network(s) shall be reviewed and a determination made by the Credentials Committee.
Policy 6 (Skipped Intentionally)

Policy 7 Site Visits

A. Anthem will establish specific criteria and threshold standards related to sites where network practitioners provide medical care for 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 9 Recredentialing

All applicable Practitioners and HDOs in Anthem's network are required to be recredentialled at least every (3) three 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 recredentialing 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 re-credentialing 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 (see Credentialing Policy #4.1) will be viewed as meeting all criteria and will be classified in the re-credentialing process as Level I providers (See Credentialing Policy #4.1). Level I HDO's may be approved by the chair/vice-chair of the CC or a medical director designee as noted in Credentialing Policy #3.

  1. Non-accredited HDOs: in the absence of this accreditation, HDOs must meet exception criteria as outlined in Credentialing Policy #4.1 (Professional Competence and Conduct Criteria - Health Delivery Organizations).

- 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 along with the rationale presented, and determine if either a material omission has occurred or if credentialing criteria are met.

a. 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 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 and re-credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices in re-credentialing Practitioners. Should discriminatory practices be identified through audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.
Policy 10 Termination and Immediate Termination

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 regarding a Practitioner’s or HDO’s professional conduct and/or competence shall be reviewed by the chair/vice-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 provider network(s) 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 or a Provider has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHBP programs, a process for immediate termination exists. In such instances, the chair/vice-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 provider network(s), 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, the process set forth in the NPDB 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. 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. 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 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 or NPDB.

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 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 shall be in accordance with the current guidelines
established for such databank.

B. Reporting Requirements to the National Practitioner 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 https://npdb.hrsa.gov.

All reports to the NPDB must be submitted electronically. Reports will be submitted via the Internet using
the Integrated Querying and Reporting Service (IQRS), or on diskette in a format specified by the
NPDB. Details on the format specified for submissions may be obtained by calling the NPDB 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 must be sent to the State Agency and/or NPDB 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 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.

If errors or omissions are found after information has been reported to State Licensing Agency,
corrections must be submitted by annotating the “Report Verification Document” or by submitting a
new, fully completed “Adverse Action Report” form. There are two categories of changes to an
“Adverse Action Report,” CORRECTION OR ADDITION and VOID PREVIOUS REPORT. A
CORRECTION OR ADDITION supersedes, or adds information to, the current version of a report.
A VOID PREVIOUS REPORT retracts a report in its entirety, and the report is treated as though it
had not been submitted (i.e., a report was made on the wrong Practitioner)

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 NPDB 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 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 Reporting Questions:

Then questions arise regarding querying or reporting requirements, the Compliance Staff will call the NPDB 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 Appeals - Practitioners

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 practitioners 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 practitioners 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 practitioners 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.
Participating Practitioners whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB 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 practitioner via certified letter of the decision. The notice will contain:

   i. the reason for the decision, and

   ii. a statement that the practitioner has the opportunity for an Informal Review/reconsideration of the decision and that the practitioner 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 practitioner 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 practitioner 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 practitioner wishes to be considered.

   b. Denial of Initial Applicants.

   When initial application is rejected by Anthem’s CC, the credentialing staff will notify the practitioner via certified letter of the decision. The letter will contain: the reason for the decision, a statement that the practitioner has the opportunity for an Informal Review/reconsideration of the decision and that the practitioner 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 practitioner 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 practitioner may request a Reconsideration/Informal Review of a CC decision which is adverse to the practitioner'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 practitioner 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 practitioner
under review may provide written information, but is not present during the CC meeting. For initial determinations, if the information submitted by the practitioner 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 practitioner 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 practitioner via certified mail within fourteen (14) calendar days of the decision. For practitioners 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 practitioner 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 practitioner is eligible for Formal Appeal, a statement that:

   i. The practitioner 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 practitioner desires an appeal, the practitioner 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 practitioner wishes to be considered.

When the practitioner 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 practitioner to credentialing staff.

B. Formal Appeal

1. Formal Appeal Hearing, Upon Request.

A practitioner 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 practitioner’s receipt of the notice from Anthem. If a practitioner 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 practitioner’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. Three (3) to seven (7) practitioners not involved in the original decision:
ii. Must be credentialed and by Anthem and in good standing;
iii. The hearing panel will be chaired by Anthem’s Medical Director, or designee, who is
entitled to vote and who is counted as a member of the hearing panel;
iv. May not be the same individual who chair or vice-chairs the geographic CC;
v. No person who is in direct economic competition with the practitioner may serve on the
hearing panel; and
vi. Only hearing panel members not involved in the original decision may vote.
vii. 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 practitioner’s
request for a Formal Appeal, the credentialing staff will send a certified letter notifying the
practitioner of the date, time, and place of the formal hearing. It will advise the practitioner
that he/she may appear in person or by telephone. This letter will also summarize the hearing
procedures and notify the practitioner that he or she may appear with a legal representative
or other designee before the hearing panel, and that such practitioner has the right to:

i. have a record made of the proceedings, copies of which may be obtained by the
practitioner 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.

viii. Such notice will also state that the Practitioner will forfeit his or her right to a hearing if the
Practitioner fails to attend the hearing (either in person or by telephone) without good cause
or request a hearing within thirty (30) days. If a Practitioner has forfeited his/her right to a
hearing, the Adverse Credentialing Decision will stand.

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 practitioner. 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 practitioner of the date, time, and place of the
formal hearing or as otherwise agreed to by Anthem and the affected practitioner.

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 practitioner 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 practitioner.
c. The practitioner 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 practitioner 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 practitioners participating in a Medicare Advantage Network, the Formal Hearing will follow this rule:


a. Formal Hearing, Upon Request.

i. Hearing Panel.

When the practitioner requesting the Formal Hearing is a physician in the Medicare Advantage program, the Anthem Medical Director or designee will select the 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 – Appeals – Facilities

It is the intent of Anthem to give HDOs the opportunity to appeal a termination of the HDOs participation in one or more of Anthem’s provider network(s) or programs. Immediate terminations may be imposed due to the HDOs loss of licensure, criminal conviction of one of the principal officers of the HDO or Anthem’s determination that the HDOs continued participation poses an imminent risk of harm to Anthem’s covered individuals, or the HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs. An HDO whose license has been suspended or revoked has no right to Informal Review/Reconsideration or Formal Appeal. An HDO whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Informal Review/Reconsideration:

a. Notice:
Terminations of Participating Providers:

i. Upon decision by the geographic CC to terminate a HDO’s participation, the credentialing staff will notify the HDO via certified letter of the decision. The notice will contain the reason for the decision, a statement that the Provider has the opportunity for an Informal Review/reconsideration of the decision, a statement that the provider has the right to submit additional information to Anthem for Informal Review/Reconsideration and a summary description of the review process described below. In addition, the notice will also advise that the HDO has the right to waive the Informal Review thus proceeding to a Formal Hearing, and that proceeding directly to a Formal Hearing waives any future right to an Informal Hearing. The notice also will state that if the Provider desires any further review, the HDO representative 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. A request for any additional review shall stay the effective date of the termination unless otherwise required by state law or regulation or by contract. For information regarding immediate terminations, see Credentialing Policy #10.

b. Request for Reconsideration/Informal Review:

The HDO may request a Reconsideration/Informal Review of the geographic CC’s decision if the decision of the geographic CC is adverse to the provider. This request must be in writing, sent via certified mail, and received by the credentialing department within the thirty (30) calendar day period immediately following the date of the HDO’s receipt of the letter from Anthem (unless otherwise required by state regulation), with its determination based on the committee results. (See “Appendix A” for those plans with Meet and Confer Language in Provider Contract).

c. Process:

Any additional information submitted subsequent to the initial decision will be reviewed by the credentialing staff for Informal Review/Reconsideration. The credentialing staff will review the information used as the basis for the initial decision, along with any additional information submitted by the HDO and if appropriate, forward the matter including any additional information submitted by the HDO to the geographic CC at its next meeting. No representatives of the HDO shall be present during the Informal Review/Reconsideration. For initial determinations, if the information submitted by the HDO contains no new objective information, it may be presented in summary form.

d. Informal Review/Reconsideration:

As reconsideration, any additional information submitted subsequent to the initial decision of the geographic CC will be presented to the committee for its consideration. All of the conditions of Credentialing Policy #3 with regards to the geographic CC apply. The geographic CC will review the information obtained during the credentialing process and the basis for its initial decision, along with any additional information submitted by the HDO. This review may take place at regularly scheduled geographic CC meeting or at a special review meeting. The representatives of the HDO shall not be present during the review. Anthem may have credentialing staff, network service representatives and legal representatives present for the first level review as non-voting members.

e. Review Results:

The geographic CC shall report its decision on the Reconsideration/Informal Review to the credentialing department within five (5) business days of its decision. The credentialing staff shall notify the HDO via certified mail within fourteen (14) calendar days of the decision.

Formal Appeal Process:

a. Notice:

Upon notification that Reconsideration/Informal Review of a decision to terminate an HDO’s participation of a Professional Review Action was upheld by the geographic CC, the credentialing staff will notify the entity via certified letter of the decision. The notice will:

i. Contain the reason for the decision;

ii. Where an HDO is eligible for Formal Appeal, a statement that:

1. The HDO has the opportunity to submit additional information to Anthem for appeal of the decision; and
2. A summary description of the appeal process described below.
   iii. State that if the HDO desires an appeal, the entity must submit, within the thirty (30)-calendar-day-period immediately following the date of receipt of the notice (unless otherwise required by state regulation):
       1. Written request to the credentialing department for an appeal of the decision; and
       2. Any additional information the HDO wishes to be considered.

A request for a Formal Appeal shall stay the effective date of the termination, unless otherwise required by state law or regulation or by contract.

b. Formal Appeal Hearing, Upon Request:
   A HDO which has been terminated from the network may request a formal appeal hearing if the decision of the first level review is adverse to the HDO or if the right to first level review was waived by the HDO. This request must be in writing and received via certified mail within the thirty calendar (30) day period immediately following the date of the HDO’s receipt of the notice from Anthem. If an HDO timely requests a hearing, the following procedures will be followed:

   • The credentialing staff will notify Anthem’s Medical Director, and Anthem’s legal counsel, of the Provider’s request for a hearing.
   • Hearing Panel:
     i. Anthem Medical Director or designee will select the members of the hearing panel. The hearing panel will be comprised of at least three (3) individuals not involved in the original decision. Only hearing panel members not involved in the original decision may vote. No person with an economic interest in an entity in direct competition with the appealing HDO may serve on the hearing panel. At least one of the hearing panel members will be a participating provider with some experience with the type of HDO in question, but without any other role in network management. The hearing panel will be chaired by Anthem’s Medical Director, or designee, who is entitled to vote and who is counted as a member of the hearing panel.
   • Hearing Notice:
     i. Within thirty (30) business days of receipt by Anthem of a request for a Formal Appeal, the credentialing staff will send a certified letter notifying the HDO of the date, time, and place of the formal hearing. It will advise the representatives of the HDO that it may have its representative appear in person or by telephone. This letter will also summarize the hearing procedures and notify the HDO representative that he or she may appear with a legal representative or other designee before the hearing panel, and that the entity and its representatives have the right to:
       1. Have a record made of the proceedings, copies of which may be obtained by representative(s) of the HDO upon payment of any reasonable charges associated with the preparation thereof;
       2. Call, examine, and cross-examine witnesses;
       3. Present evidence determined to be relevant by the hearing panel regardless of its admissibility in a court of law;
       4. Be represented by an attorney or another person of their choice;
       5. Submit a written statement at the close of the hearing;
       6. 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 HDO will forfeit its right to a hearing if the representative(s) of the HDO fail(s) to attend the hearing (either in person or by telephone) without good cause or request a hearing within thirty (30) days. If a HDO has forfeited the right to a hearing, the Adverse Credentialing Decision will stand.

   • 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 HDO. The panel members may also be provided with any other material deemed relevant by Anthem at or in advance of the hearing.
   • Hearing Date:
     i. 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 HDO of the date, time, and place of the formal hearing or as otherwise agreed to by Anthem and the affected HDO.
c. **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.
     1. During the hearing, the HDO representative will have the ability to exercise any or all of the rights set forth in Section “Hearing Notice” above.
     2. A representative of Anthem will present the reasons for the decision to reject or terminate the HDO.
     3. The representative of the HDO will present reasons why his or her participation should not be rejected or terminated.
     4. Before the close of the hearing, each side may briefly summarize its position for the hearing panel if it chooses.
     5. 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.
     6. 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.
     7. The hearing panel will prepare a written decision, including the rationale, for its decision.

d. **Review Results:**
   - 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 HDO 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.

e. **Reporting Final Adverse Actions:**
   - Anthem will report any final adverse actions in accordance with applicable local regulations.

**Policy 15 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 16 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) they 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 17 – Specialty Designations

i. Anthem recognizes all provider specialty designations recognized by the American Board of Medical Specialties (ABMS), the Healthcare Facilities Accreditation Program (HFAP), 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, HFAP, 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.

ii. For provider types which are in the scope of the credentialing program, but for which the ABMS/HFAP/RCPSC/CFPC/ACGME is not applicable, the National Credentials Committee will establish acceptable education and training requirements for recognition (see below) Any specialty recognized by Anthem is eligible for use in provider directories, but determination of need for a specific eligible specialty designation is that of Anthem. In situations where there are extenuating or special circumstances an Access Needs Waiver must be completed and reviewed by the National Credentials Committee.

Anthem recognized specialty types with education and training requirements:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>Training Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Practice</td>
<td>Meets the criteria outlined in Credentialing Policy #4.0.</td>
</tr>
<tr>
<td>NCC Approval date: 03/13/2015</td>
<td></td>
</tr>
<tr>
<td>Gynecology</td>
<td>Same training as obstetrics/gynecology (4 years accredited graduate medical education in an Obstetrics/Gynecology program with no less than 36 months of clinical Obstetrics/Gynecology). This designation is per the applying physician’s choice in place of, but in addition to, the designation of obstetrics/gynecology.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine and Pediatrics</td>
<td>1. Board Certified in both Internal Medicine AND Pediatrics OR</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Addiction Medicine</td>
<td>ABMS recognized pathway through psychiatry or HFAP certification.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Sleep Medicine</td>
<td>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).</td>
</tr>
<tr>
<td>NCC Approved</td>
<td></td>
</tr>
<tr>
<td>Pediatric Orthopedics</td>
<td>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.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Pediatric Urology</td>
<td>Completion of a recognized ACGME training program in Pediatric Urology OR Board Certified in Urology and having urology privileges at a pediatric specialty hospital.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Pediatric Ophthalmology</td>
<td>Board Certified in Ophthalmology and having privileges in ophthalmology at a pediatrics specialty hospital.</td>
</tr>
<tr>
<td>NCC Approval Date: 12/21/05</td>
<td></td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
</tr>
<tr>
<td>---------------------------------------------</td>
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</tr>
<tr>
<td>Pediatric Neurosurgery</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<td></td>
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<tr>
<td>Pediatric Cardiac Surgery</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Allergy &amp; Immunology</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
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<tr>
<td>Glaucoma</td>
<td>12/21/05</td>
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<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
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<tr>
<td>Retinal Disease</td>
<td>12/21/05</td>
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<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Adult Reconstructive Orthopedics</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Foot and Ankle Orthopedics</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthopedic Trauma</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
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<tr>
<td></td>
<td></td>
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<tr>
<td>Orthopedic Surgery of the Spine</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Pain Medicine</td>
<td>12/21/05</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td>07/10/09</td>
</tr>
<tr>
<td>Specialty</td>
<td>NCC Approval Date</td>
</tr>
</tbody>
</table>
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, Certified Nurse Midwives, and Physician Assistants
6. Medical Therapists, e.g. physical therapists, speech therapists, and occupational therapists, who are within the scope of credentialing (See Credentialing Policy #2)
7. Licensed Genetic Counselors
8. Audiologists
9. Acupuncturists (non-MD/DO)

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 CIHQ, TJC, NIAHO- or HFAP-approved facility
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.
18. Pathologists practicing in an office 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.
## 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) Website: <a href="http://www.jointcommission.org">www.jointcommission.org</a></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>
</tr>
<tr>
<td>HFAP – Healthcare Facilities Accreditation Program (formerly referred to as American Osteopathic Association Hospital Accreditation Program) Website: <a href="http://www.hfap.org">www.hfap.org</a></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 &amp; resurvey within 1 year</td>
<td>Accreditation &amp; resurvey within 3 years, Accreditation &amp; resurvey within 2 years</td>
</tr>
</tbody>
</table>
## 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>NIAHO</td>
<td>Hospitals, Outpatient Podiatric Surgical Facilities</td>
<td>Accreditation 1 year Accreditation for 3 years For facilities in existence for less than 6 months, contingency accreditation with follow up in 1 year May also accredit for less than 3 years if the organization is in substantial compliance</td>
<td>Accreditation 1 year In force accreditation as confirmed by the agency's website</td>
</tr>
<tr>
<td>AAPSF Accreditation Association Podiatric for Surgical Facilities</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Website: <a href="http://www.aapsf.com">www.aapsf.com</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAAHC Accreditation Association for Ambulatory Health Care</td>
<td>Ambulatory Surgery Facilities, Free Standing Lithotripsy Centers</td>
<td>Accreditation for 3 years Accreditation for 1 year Accreditation for 6 months</td>
<td>Accreditation for 3 years Accreditation for 1 year</td>
</tr>
<tr>
<td>Website: <a href="http://www.aaahc.org">www.aaahc.org</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accreditation Commission for Health Care</td>
<td>Home Health Care Agencies</td>
<td>Accreditation for 3 years</td>
<td>Accreditation for 3 years</td>
</tr>
<tr>
<td>Website: <a href="http://www.achc.org">www.achc.org</a></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AAAASF American Association for Accreditation of Ambulatory Surgery Facilities</td>
<td>Outpatient surgery facilities Offers Class A-C Professional accreditation depending upon the level of surgery and anesthesia required by the procedures Class “A” facilities are those where procedures are performed under local or topical anesthesia</td>
<td>Full Accreditation (valid for 3 years) Provisional Accreditation</td>
<td>Full Accreditation of a class appropriate to the procedures performed at the Professional</td>
</tr>
</tbody>
</table>
### 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>
</table>
| Institute for Medical Quality  
Website: [www.imq.org](http://www.imq.org) | Ambulatory Facilities | 6 Month Accreditation  
1 year Accreditation  
3 year Accreditation | 3 year Accreditation with National Fire Code Protection (NFPA) Life Safety Code Compliance Module |
| 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  
Impatient  
Outpatient  
Partial Hospitalization  
Day Treatment | Accreditation for 3 years  
Accreditation for 1 years  
Provisional Accreditation | Accreditation for 3 years  
Accreditation for 1 years |
| **Continued** | |

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/entotracheal intubation.
## 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>CHAP Community Health Accreditation Program Website: <a href="http://www.chapinc.org">www.chapinc.org</a></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>
</tr>
</tbody>
</table>

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### Quality Improvement Program

#### Quality Improvement Program Overview

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

Annually, a QI Work Plan is developed and implemented with the goal of improving the level of services and care provided to Covered Individuals. The QI Work Plan also reflects ongoing progress on priority QI metrics.

The QI Evaluation assesses the overall effectiveness of the QI Program and the outcomes of the QI metrics defined in the QI Work Plan. The QI Evaluation also determines how the QI Program goals and objectives were met.

To see a summary of Anthem’s QI Program and most current outcomes, visit us online. Go to anthem.com, and select the Providers link at the top of the landing page (under the “Other Anthem Websites” section). Select your state from the drop down list and enter. On the Provider Home page, under the Health & Wellness tab (on the blue toolbar) select Quality Improvements and Standards, then the link titled “Quality Improvement Program.”

Goals and Objectives

The following QI Program goals and objectives have been adopted to support Anthem’s vision and values and to promote continuous improvement in quality care, patient safety, and quality of service to our Covered Individuals, Providers and Facilities.

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

Quality and Safety of Clinical Care

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

- **Behavioral Health Programs**: Anthem focuses on improving the coordination between medical and behavioral health care, with programs specifically addressing conditions such as alcohol and other drug use, depression, attention deficit hyperactivity disorder, bipolar disorder, eating disorders, and autism.

- **Patient Safety**: Anthem works with Providers, Facilities, and other healthcare providers to help reduce adverse health care-related events and unnecessary cost of care, as well as to develop innovative programs to encourage improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient empowerment, care management, and payment innovation.

- **Continuity and Coordination of Care**: Anthem’s goal is to help improve continuity and coordination of care across Providers and other health care professionals through interventions that promote timely and accurate communication.

- **Community Health**: Anthem addresses public health priorities including behavioral health, cancer, diabetes, maternal/child health, obesity, patient safety, and smoking cessation by collaborating with key stakeholders in the industry. These focus areas are aligned with the Anthem Foundation’s goals, measured through State Health Index (SHI) to assess performance trend and improvement opportunities. We aim to improve and measure the health of Anthem members and communities around key clinical areas through collaborations with community organizations. We also work closely with our business partners and the Anthem Foundation to ensure that our efforts are closely aligned. Some of our innovative programs include:
  - Web based resources for managers to support employees’ healthy return to work after cancer treatment. *(Work Plan Transitions for People Touched by Cancer)*
  - Smoking Cessation Program that helps to reduce smoking as well as premature and underweight births. *(Baby & Me - Tobacco Free)*
  - Digital Magazine featuring free resources available to all people touched by cancer. *(Stronger Together)*
  - Diabetes program that promotes successful aging through lifelong learning, healthy living and social engagement in collaboration with the National Council on Aging (NCOA), the Oasis Institute, and YMCA. *(Better Choices Better Health)*
• **Care Management for Chronic Health Conditions:** Anthem’s integrated suite of ConditionCare programs is designed to help maximize health status, help improve health outcomes, and help reduce health care costs of Covered Individuals diagnosed with Asthma (pediatric and adult), Diabetes (Type 1 and Type 2, pediatric and adult), Coronary Artery Disease (CAD), Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD).

These disease management programs were created and developed based on the most recent versions of nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two (2) years and program interventions and protocols are updated accordingly.

**Service Quality**

Anthem periodically surveys its Covered Individuals and uses other tools to assess the quality of care and service provided by our Providers and Facilities. We also strive to provide excellent service to our Covered Individuals, Providers, and Facilities. Anthem analyzes trends to identify service opportunities and recommends appropriate activities to address root causes.

**Member Rights and Responsibilities**

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

**Patient Safety**

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

**Continuity and Coordination of Care**

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

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

- **Journey Forward Program.** This program (developed by a collaborative among Anthem, Inc., UCLA’s Cancer Survivorship Center, the National Coalition for Cancer Survivorship, the Oncology Nursing Society, Genentech, and the Cancer Support Community) aims to improve the long-term health of cancer survivors by enhancing Providers’ and their patients’ understanding of the late effects of cancer treatment and...
survivorship and facilitating the use of *Survivorship Care Plans* (documents that include a treatment summary and guidance for follow-up care post cancer treatment) through a suite of technology tools for Providers and their patients. This is a part of the broader goal to improve the long-term care for cancer survivors by enhancing the continuity and coordination of care between primary and oncology care during and after cancer treatment.

- **The Controlled Substances Utilization Management Program.** This program alerts physicians about Covered Individuals who are their patients and have \( \geq 10 \) claims for controlled substances in a 90-day period and includes a list of the Covered Individuals’ controlled substance prescriptions and prescribing physician to help make sure care is being appropriately coordinated. The information provided to the physician is intended to complement his or her direct knowledge of the Covered Individual, allowing an increased opportunity to evaluate appropriateness of drug therapy, discontinue drug therapy that may no longer be necessary, coordinate drug therapy with other Providers and Facilities and help detect potentially fraudulent prescriptions or prescription use.

- **The Polypharmacy Program.** This program identifies Covered Individuals who have filled prescriptions for medications in ten or more therapeutic classes from three or more unique prescribers within a three month period and aims to help reduce injury and adverse events due to polypharmacy drug use. Key features of the Polypharmacy Program include messaging to Providers and Facilities about Covered Individual polypharmacy utilization and significant drug-drug interactions.

- **Surveys to Assess Coordination of Care.** Anthem conducts a survey with PCPs regarding their satisfaction with the timeliness of communication from other physicians and facilities that treat Covered Individuals. Part of this survey includes a section regarding communication with behavioral health practitioners. Behavioral health practitioners are also surveyed regarding satisfaction with care management, claims, customer service, and communication and coordination of care between PCPs and other behavioral health practitioners.

- **Comorbid Medical Behavioral Health Program.** The primary goal of the program is to provide Covered Individuals who have chronic medical conditions with a comprehensive behavioral health case management program to address overall needs, support Covered Individuals in seeking appropriate levels of care, and enhance treatment compliance. Behavioral Health staff helps to facilitate the coordination of care between medical and behavioral health providers for all consenting Covered Individuals. The results of the symptom screenings are communicated to the PCP (or other community physician of Covered Individual’s choice) as well as the referral source.

- **Severe and Persistent Mental Illness (SPMI) Program.** The primary goal of the program is to provide Covered Individuals who have chronic behavioral health conditions with a comprehensive behavioral health case management program to address overall needs, support Covered Individuals in seeking appropriate levels of care, enhance treatment compliance, and improve overall well-being. SPMI is defined as a diagnosable mental, behavioral, or emotional disorder (e.g., schizophrenia, bipolar disorder, major depression) that results in functional impairment, which substantially interferes with or limits one or more major activities (e.g., maintaining interpersonal relationships, activities of daily living, self-care, employment, recreation). Behavioral Health staff helps to facilitate the coordination of care between medical and behavioral health providers for all consenting Covered Individuals. The results of the symptom screenings are communicated to the treating psychiatrist (or other community physician of Covered Individual’s choice in cases where there is no treating psychiatrist).

- **Antidepressant Medication Management Program.** In support of appropriate clinical practice, Anthem has this member-focused intervention to promote optimal use of antidepressant medications. All Anthem Covered Individuals who newly start an antidepressant medication receive an individualized educational mailing and a telephone call utilizing automated voice recognition (IVR) technology. The IVR call encourages Covered Individuals to stay on their medication, and if they have questions or concerns, they are directed to the prescribing practitioner. When Covered Individuals are more than seven (7) days late in refilling their antidepressant medication, during the first one hundred eighty (180) calendar days of therapy, a late refill IVR reminder call is made. The prescribing practitioner is also notified via written communication of the member’s late refill.
Continuity of Care/Transition of Care Program

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

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

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

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

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

Performance Data

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

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

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

Additional Information on Anthem’s Quality Improvement Programs

Additional information on Anthem’s Quality Improvement programs can be found on anthem.com. Select the Providers link at the top of the landing page (under the “Other Anthem Websites” section). Select your state from drop down list and enter. On the Provider Home page, under the Health & Wellness tab (on the blue toolbar) select Quality Improvement and Standards.
Overview of HEDIS®

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

HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA)

Overview of CAHPS®

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

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

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

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

Clinical Practice Guidelines

Anthem considers clinical practice guidelines to be an important component of health care. Anthem adopts nationally recognized clinical practice guidelines, and encourages physicians to utilize these guidelines to improve the health of our Covered Individuals. Several national organizations such as, National Heart, Lung and Blood Institute, American Diabetes Association and the American Heart Association, produce guidelines for asthma, diabetes, hypertension, and other conditions. The guidelines, which Anthem uses for quality and disease management programs, are based on reasonable medical evidence. We review the guidelines at least every two years or when changes are made to national guidelines for content accuracy, current primary sources, new technological advances and recent medical research.
Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through the Internet. To access the guidelines, go to anthem.com. Click on the Provider link at the top of the landing page (under the “Other Anthem Websites” section). Select your state and click enter. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled “Clinical Practice Guidelines”.

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

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**Preventive Health Guidelines**

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

The current guidelines are available on our website. To access the guidelines, go to anthem.com. Click on the Provider link at the top of the landing page (under the “Other Anthem Websites” section). Select your state and click enter. On the Provider Home page, under the Health and Wellness tab (on the blue toolbar) select or scroll to the practice guidelines, then select the link titled “Preventive Health Guidelines”.

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

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**Medical Record Standards**

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

For more information on Medical Record standards, please go to the “Provider” home page at anthem.com. Click on the “Provider” link at the top of the new landing page (under the “Other Anthem Websites” section). Select your state and click enter. On the Provider home page under the Health and Wellness tab (on the blue toolbar), choose Quality Improvement and Standards, and then scroll down to “Medical Record Review”.

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Cultural Diversity and Linguistic Services

Cultural Diversity and Linguistic Services Overview

Anthem recognizes that Providers can encounter challenges when delivering health care services to a diverse population. Those challenges arise when Providers need to cross a cultural divide to treat patients who may have different behaviors, attitudes, and beliefs concerning health care, or who speak a different language. Differences in patients’ ability to speak or read the same language as their health care providers may add an extra dimension of difficulty when Providers try to encourage follow-through on treatment plans.

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

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

We strongly encourage Providers to access the complete toolkit:

http://bridginghealthcaregaps.com/

The toolkit contents are organized into the following sections:

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

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

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

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

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

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

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

Cultural competency training available on anthem.com

Creating an LGBT-Friendly Practice: Bridging Multicultural Health Care Gaps

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

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

To view more offerings go to anthem.com. Click on the Provider link in the top of the landing page (under the “Other Anthem Websites” section). Select your state and click enter. From the Provider Home page, select the Health & Wellness tab then select the Cultural and Linguistic link, then scroll down to Training: Cultural and Linguistic CME Courses.
Member Health and Wellness Programs

Providers can find more information about our Member Health and Wellness Programs on our public provider website under the Health & Wellness menu. MyHealth@Anthem and Comprehensive Medical Management are available to all Anthem members. Other programs offered may vary depending on the Covered Individual’s Health Benefit Plan. Visit www.anthem.com >Provider Home page > Health & Wellness (found under Find a Doctor)

Programs at a Glance:

<table>
<thead>
<tr>
<th>Program</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>24/7 NurseLine</td>
<td>Anytime, toll-free access to highly-experienced, registered nurses for answers to general health questions and guidance with critical health concerns.</td>
</tr>
<tr>
<td>ComplexCare</td>
<td>Intense outreach and coordination from registered nurses specialized in managing the complex needs of Covered Individuals with multiple health conditions. Access to multidisciplinary team and input from the Medical Director.</td>
</tr>
<tr>
<td>Comprehensive Medical Management</td>
<td>In the face of a health crisis, one-on-one expert assistance ensuring the right services and care are received; advocate to ensure that benefits are utilized effectively and necessary medical interventions are appropriate and safe.</td>
</tr>
<tr>
<td>ConditionCare</td>
<td>Registered Nurses who are committed to helping Covered Individuals with chronic conditions better manage and improve their health. Conditions include: asthma, diabetes; chronic obstructive pulmonary disease (COPD); coronary artery disease; heart failure</td>
</tr>
<tr>
<td>ConditionCare for Kidney Disease</td>
<td>ConditionCare for Kidney Disease provides ongoing support to Covered Individuals with Chronic Kidney Disease or ESRD to help manage this condition.</td>
</tr>
<tr>
<td>Future Moms</td>
<td>Support from trained obstetrical nurses in an award-winning maternity management program dedicated to helping expectant parents have a healthy pregnancy and delivery.</td>
</tr>
<tr>
<td>Healthy Lifestyles</td>
<td>A team of specially trained health professionals that helps Covered Individuals take decided steps toward improved health in key areas that are prevalent and persistent; weight management; stress management; physical activity; diet and nutrition; smoking cessation.</td>
</tr>
<tr>
<td>MyHealth@Anthem</td>
<td>Personalized, online health information that drives Covered Individuals to become more involved in their health. Includes dynamic online tools such as MyHealth Assessment and My Health Record.</td>
</tr>
<tr>
<td>My Health Advantage</td>
<td>Includes timely alerts in the mail called MyHealth Notes that notify Covered Individuals of possible gaps in care, issues with medications or ways to save money. Early detection of potential health issues may lead to decreased healthcare costs for Covered Individuals and employers.</td>
</tr>
<tr>
<td>MyHealth Coach</td>
<td>A personal registered nurse who is available to the entire family as a health and lifestyle coach. An experienced guide who can help Covered Individuals navigate their health benefits.</td>
</tr>
<tr>
<td>Staying Healthy Reminders</td>
<td>Targeted postcards reminding Covered Individuals and their families when it is time for certain preventative care and screenings such as immunizations and mammograms.</td>
</tr>
<tr>
<td>Worksite Wellness</td>
<td>A jump start to improve health on the job. Onsite programs that promote better health and cover everything from flu shots and health screenings to wellness seminars to therapeutic massage.</td>
</tr>
</tbody>
</table>
Centers of Medical Excellence

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

Anthem Covered Individuals have access through this program to Centers of Medical Excellence, including Blue Distinction Centers for Specialty Care for transplant, cardiac care, bariatric surgery, complex and rare cancers, spine surgery, and knee/hip replacements.

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

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the facility delivers specialty care. More information on our programs can be accessed online.

http://www.anthem.com/wps/portal/ahpprovider?content_path=/provider/noapplication/f2/s3/t0/pw_ad094863.htm&rootLevel=1&state=va&label=Centers%20of%20Medical%20Excellence

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

Cardiac Care
- Blue Distinction Centers for Cardiac Care® launched in January 2006.
- According to the Centers for Disease Control and Prevention, approximately 610,000 people die of heart disease in the United States every year—that’s 1 in every 4 deaths.
• Research shows that Blue Distinction Centers and Blue Distinction Centers+ demonstrate better quality and improved outcomes for patients, with lower rates of complications following certain cardiac procedures and lower rates of healthcare associated infections compared with their peers. Blue Distinction Centers+ are also 20 percent more cost-efficient than non-designated hospitals for those same cardiac procedures.

• Blue Distinction Centers and Blue Distinction Centers+ for Cardiac Care provide a full range of cardiac care services, including inpatient cardiac care, cardiac rehabilitation, cardiac catheterization and cardiac surgery (including coronary artery bypass graft surgery).

Bariatric Surgery
• Blue Distinction Centers for Bariatric Surgery® launched in 2008
• Morbid obesity is widely recognized as a contributor to serious health risks. According to the Centers for Disease Control and Prevention, approximately 72 million Americans are obese. The American Society for Metabolic and Bariatric Surgery estimates that approximately 179,000 bariatric surgeries were performed in 2013. Blue Distinction provides objective information to help patients make informed decisions when choosing a provider for bariatric surgery.

• Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS), and is subject to periodic re-evaluation as criteria continue to evolve.

• The Blue Distinction Centers for Bariatric Surgery program is available to comprehensive centers with inpatient capability or freestanding ambulatory surgical centers (ASCs). The Blue Distinction Centers for Bariatric Surgery program designation includes two types:
  - Gastric Stapling
  - Gastric Banding

Complex and Rare Cancers
• Blue Distinction Centers for Complex and Rare Cancers® launched in 2008.
• The Blue Distinction Centers for Complex and Rare Cancers program offers access to designated facilities for the treatment of 13 complex and rare cancers including esophageal cancer, pancreatic cancer, liver cancer, rectal cancer, gastric cancer, bone tumors, soft tissue sarcomas, brain tumors – primary, non-metastatic malignancies, bladder cancer, thyroid cancer – medullary or anaplastic, ocular melanoma, and head and neck cancers.

• Complex and Rare Cancers comprise approximately 15 percent of new cancer cases each year. The Blue Distinction Centers for Complex and Rare Cancers program evaluates facilities on patient assessment, treatment planning, complex inpatient care and major surgical treatments for adults; all delivered by teams with distinguished expertise and subspecialty training for complex and rare cancers. The Blue Cross and Blue Shield Association recognizes that the majority of patients’ multidisciplinary treatment may be best accomplished by integrating the expertise available in a Blue Distinction Center with locally available treatment resources, especially for outpatient chemotherapy and radiotherapy, based on individual circumstances and patient preference. Optimal support of a patient’s comprehensive cancer care needs may be achieved by coordination of care between the patient and their family, local physicians, the Blue Distinction Center and their local Blue Cross and Blue Shield Plan.

• The Blue Distinction Centers for Complex and Rare Cancers program was developed in collaboration with the National Comprehensive Cancer Network (NCCN), with input from a panel of nationally recognized clinical experts and utilizing published evidence, where available.

Spine Surgery
• Blue Distinction Centers for Spine Surgery® launched in November 2009.

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

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

Maternity Care
• Blue Distinction Centers and Blue Distinction Centers+ for Maternity Care (coming in 2016) will
  include healthcare facilities with demonstrated expertise and a commitment to quality care during the
delivery episode of care, which includes both vaginal and cesarean section delivery.
• The Maternity Care designation uses publicly available data from Hospital Compare data which includes the
  Early Elective Delivery (PC-01) and elected patient experience measures at the facility level from Hospital

Member Quality of Care (“QOC”) Investigations

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

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

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

Trends/patterns of all assigned severity levels are reviewed with the Medical Director for intervention and corrective
action planning.
Corrective Action Plans (“CAP”)

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

Reporting

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

Severity Levels for Quality Assurance

<table>
<thead>
<tr>
<th>Quality of Care</th>
<th>Points Assigned</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>C-0</td>
<td>0</td>
<td>No quality of care issue found to exist.</td>
</tr>
<tr>
<td>C-1</td>
<td>0</td>
<td>Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.</td>
</tr>
<tr>
<td>C-2</td>
<td>5</td>
<td>Communication, administrative, or documentation issue that adversely affected the care rendered.</td>
</tr>
<tr>
<td>C-3</td>
<td>5</td>
<td>Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.</td>
</tr>
<tr>
<td>C-4</td>
<td>10</td>
<td>Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.</td>
</tr>
<tr>
<td>C-5</td>
<td>15</td>
<td>Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.</td>
</tr>
<tr>
<td>C-6</td>
<td>25</td>
<td>Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.</td>
</tr>
</tbody>
</table>

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

Quality of Care and Service Trend Parameters

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

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

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

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

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

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

Product Summary

BlueCard

Please refer to the Communications section on www.Anthem.com or its successor for additional information or the BlueCard section of this manual.

Federal Employee Health Benefit Program (FEHBP) Website

Please refer to the Federal Employee Program (FEP) Website at www.fepblue.org for additional information. You can also refer to the FEP section of this manual.
Medicaid Provider Website

Please refer to the Medicaid website online for additional information at http://www.anthem.com/mediproviders.

Medicare-Medicaid Plans Provider Website

Please refer to the Medicare-Medicaid website online for additional information at http://www.anthem.com/mediproviders.

Other Products

Please refer to the Plans & Benefits section on www.Anthem.com or it successor for additional information.

Medicare Advantage

Medicare Advantage Provider Website

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

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

- Medicare Advantage HMO and PPO Provider Guidebook

Medicare Crossover

Duplicate Claims Handling for Medicare Crossover

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

Effective October 13, 2013, when a Medicare Claim has crossed over, Providers are to wait 30 calendar days from the Medicare remittance date before submitting the Claim to the local Plan if the charges have still not been considered by the Covered Individual's Blue Plan.
If Provider provides Covered Individuals' Blue Plan ID numbers when submitting Claims to the Medicare intermediary, they will be crossed over to the Blue Plan only after they have been processed by the Medicare intermediary. This process will take a minimum of 14 days to occur. This means that the Medicare intermediary will be releasing the Claim to the Blue Plan for processing about the same time Provider receives the Medicare remittance advice. As a result, upon receipt of the remittance advice from Medicare, it may take up to 30 additional calendar days for Provider to receive payment or instructions from the Blue Plan.

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

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

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

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

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

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

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

For Claims submitted directly to Medicare with a crossover arrangement where Medicare makes no allowance, Providers can expect the Covered Individual’s benefit plan to reject the Claim advising the Provider to submit to their local Plan when the services rendered are considered eligible for benefit. These Claims should be resubmitted as a fresh Claim to a Provider or Facility’s local Plan with the Explanation of Medicare Benefits (EOMB) to take advantage of Provider contracts. Since the services are not statutorily excluded as defined by CMS, no GY modifier is required. However, the submission of the Medicare EOMB is required. This will help ensure the Claims process consistent with the Provider’s contractual agreement.
Effective October 13, 2013:

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

If Providers submit combined line Claims (some lines with GY, some without) to their local Plan, the Providers local Plan will deny the Claims, instructing the Provider to split the Claim and resubmit.

**Original Medicare** – The GY modifier should be used when service is being rendered to a Medicare primary Covered Individual for statutorily excluded service and the Covered Individual has Blue secondary coverage, such as an Anthem Medicare Supplement plan. The value in the SBR01 field should not be “P” to denote primary.

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

**The GY modifier should not be used when submitting:**

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

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

Providers can call the E-Solutions Help Desk at 800-470-9630, or go to the www.anthem.com/EDI webpage to request assistance with submitting electronic Claims to us. If you have any questions about where to file your Claim, please contact the Provider Customer Service phone number on the back of the Covered Individual’s ID card.

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**Federal Employees Health Benefits Program**

**FEHBP Requirements**

Providers acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program (“FEHBP”). The Anthem FEHBP encompasses the Blue Cross Blue Shield Association Service Benefit Plan, otherwise known as “Federal Employee Program®” or “FEP®”, – the health insurance Plan for federal employees. Providers 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 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 further agree that in the event of a conflict between the Provider agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.
When a conflict arises between federal and state laws and regulations, the federal laws and regulations supersede and preempt the state or local law (Public Law 105-266). In those instances, FEHBP is exempt from implementing the requirements of state legislation.

Submission of Claims under the Federal Employees Health Benefits Program

All Claims under the FEHBP must be submitted to Plan for payment within three hundred sixty-five (365) calendar days from the date of discharge or from the date of the primary payer's explanation of benefits. Providers 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 three hundred sixty-five (365) calendar day period will not begin to run until Provider receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after this three hundred sixty-five (365) calendar day period. Except where the Covered Individual did not provide Plan identification, 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 FEHBP

For erroneous or duplicate Claim payments under the FEHBP, either party shall refund or adjust, as applicable, all such duplicate or erroneous Claim payments regardless of the cause. Such refund or adjustment may be made 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 FEHBP

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

FEHBP Waiver requirements

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

FEHBP Member Reconsiderations and Appeals

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

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

The review procedures are intended to serve both contract holders and Covered Individuals. The local Plan and OPM do not accept requests for review from Providers, except on behalf of, and with the written consent of, the contract holder or Covered Individual.
Providers are required to demonstrate that the contract holder or Covered Individual has assigned all rights to the Provider for that particular Claim or Claims.

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

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

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

FEHBP Formal Provider Appeals

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

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

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

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

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

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

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

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

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at anthem.com > Provider > State> Communications >Anthem BCBS BlueCard Provider Manual

Also, see the Eligibility and Claims Submission (Provider Professional Billing Guidelines) section for some Virginia specific information regarding BlueCard.

Health Insurance Marketplace (exchanges)

Health Insurance Marketplace

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

Critical updates about the products offered on the exchange and the networks supporting these ACA compliant Plans can be found on the Health Insurance Exchange information dedicated web page. Go to anthem.com > Providers > State > Provider Home Page scroll down to > Health Insurance Exchange Information. In addition to posting information to our website, articles are published in our provider newsletter, Network Update, and sent via our email service, Network eUPDATE, to communicate information about exchanges.

Important reminders

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

Providers who have questions on their participation status are encouraged to contact Provider Services. You can find contact information at: www.anthem.com > Provider > State > Join Our Networks > Provider Representatives

Accessing the Online Provider Directory:
- Go to anthem.com
- Select the Provider link in the top center of page
- From the Provider Home tab, select the blue box titled “Find a Doctor” to search our online Provider Directory

If you are referring a Covered Individual to another provider, please verify that the provider is participating in the Covered Individual’s specific network.
It is critical that your patients receive accurate and current data related to provider availability. As outlined in your Agreement, please notify Anthem within 30 days of all changes listed below. Please note tax ID changes must be accompanied by a W-9 to be valid.

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

Please send us this information timely, preferably within 10 business days, in one of the following ways:

- Online form: [www.anthem.com](http://www.anthem.com) > Providers > State > Answers@Anthem > Provider Forms > Provider Demographic Form
- E-Mail Address: vapodemographics.com
- Fax Number: 804-354-3700
- Address:
  
  Provider Network Administration  
  Mail Drop: VA2004-N400  
  P.O. Box 27401  
  Richmond, VA 23279

You may also contract your Provider Representative. Refer to the Contact Us: (Listing of useful Telephone numbers) found in the Directory of Services Section of this manual.

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**Audit**

**Anthem Audit Policy**

This Anthem Audit Policy applies to Providers. If there is conflict between this Policy and the terms of the applicable 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 Provider Agreement the state law will apply. All capitalized terms used in this Policy shall have the meaning as set forth in the Provider Agreement between Anthem and Provider.

Coverage is subject to the terms, conditions, and limitations of a 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 that describes the duties and obligations of Anthem and the Provider, and which contains the terms and conditions upon which Anthem will reimburse Provider for Health Services rendered by Provider to Covered Individual(s).
• Appeal means Anthem’s or its designee’s review of the disputed portions of the Audit Report, conducted at the written request of a Provider and pursuant to this Policy.

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

• Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider, 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 that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for Anthem’s or its designee’s belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider and Anthem, Audit Reports shall be sent to Provider in accordance with the Notice section of the Agreement.

• Business Associate or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.

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

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

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

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

Procedure:

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

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

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

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

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

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

7. **Completion of Audit.** Upon completion of the Audit, Anthem or its designee may conduct Audits from its offices or on-site at the Provider’s location. During the Audit, the auditor will verify that the billing is free of keystroke errors. Auditors may also review the Covered Individual’s health record documents substantiating the treatment or services rendered. If such documentation is not found in the Covered Individual’s medical record, the Provider may present other documentation or Appeal the Audit findings.

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

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

**Documents Reviewed During an Audit:**

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

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

Auditors will verify that Provider’s plan of treatment reflected the Health Services delivered by the Provider. 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 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 must review, approve and document all such policies and procedures as required by The Joint Commission ("TJC") or other applicable accreditation bodies. Policies shall be made available for review by the auditor.

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

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

Procedure:

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

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

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

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

5. Upon receipt of a timely Provider response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem’s or its designee’s final Appeal Response shall address each matter contained in the Provider’s response. If appropriate, Anthem’s or its designee’s final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem’s or its designee’s final Appeal Response shall be sent via certified mail to the Provider within fifteen (15) calendar days of the date Anthem or its designee received the Provider’s 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 shall have fifteen (15) calendar days from the date of Anthem’s or its designee’s final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem’s or its designee’s final Appeal Response, and a confirming Recoupment notification will be sent to the Provider.
7. If Provider still disagrees with Anthem’s or its designee’s position after receipt of the final Appeal Response, Provider may invoke the dispute resolution mechanisms under the Agreement.

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**Fraud, Waste and Abuse Detection**

Anthem recognizes the importance of preventing, detecting, and investigating fraud, waste and abuse and is committed to protecting and preserving the integrity and availability of health care resources for Covered Individuals, clients, and business partners. Anthem accordingly maintains a program, led by Anthem’s Special Investigations Unit (SIU), to combat fraud, waste and abuse in the healthcare industry and against our various commercial plans, and to seek to ensure the integrity of publicly-funded programs, including Medicare and Medicaid plans.

**Pre-Payment Review**

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

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

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

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

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

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