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Purpose and Introduction

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

Information Sources

- Anthem Web site – An internet site available to Anthem Blue Cross and Blue Shield (“Anthem”) Network/Participating Providers at www.Anthem.com. The site provides information on:
  - Anthem products
  - Contact phone numbers
  - Provider services
  - Health information
  - Provider directories
  - Rapid Updates

- Network Update – A periodic newsletter publication designed to educate physicians, facilities and hospitals and their appropriate staff on administrative issues.

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

Legal and Administrative Requirements Overview

Privacy Policy Manual

Our Corporate Privacy Policy Manual sets forth guidelines regarding a Covered Individual’s right to access and amend information in Anthem’s possession.

The manual addresses when an authorization, signed by a Covered Individual, is required before information may be disclosed by Anthem.

The manual includes the following key points:

- Covered Individuals have the right to approve the release of information for non-routine uses of data. In certain circumstances, Anthem will obtain a specific authorization form before information is disclosed (for example, for marketing purposes).
- Covered Individuals have the right to access their medical records and to request that Anthem restrict others’ access to their confidential information.
- Anthem may use and disclosed Covered Individual’s information for routine purposes such as treatment, payment, and health care operations.
- Anthem takes reasonable precautions to protect Covered Individual information and maintain privacy in all settings. Anthem’s contracts with physicians and other providers state expectations about the confidentiality of Covered Individual information and records.
- Anthem may provide certain information to group health plans, if necessary, to administer the plan.
- Covered Individuals have the right to amend certain information and to obtain an accounting of certain disclosures.

Anthem further protects the confidentiality of Covered Individual’s medical information as follows:
Contracts for providers functioning in a peer review capacity specifically address and uphold the confidential nature of all patient medical information.

Contractual language requires all physicians participating in Anthem’s managed care products to maintain confidentiality of medical information for our Covered Individuals.

Confidentiality policies and procedures are evaluated as part of the Physician Office Review Program and during oversight visits to delegates.

Continuity and Coordination of Care

Anthem has policies and procedures in place to promote the coordination and continuity of medical care for our Covered Individuals. This includes the confidential exchange of information between primary care physicians and specialists as well as behavioral health providers. In addition, Anthem helps coordinate care when the provider’s contract has been discontinued to help with a smooth transition to a new provider.

Appointment Access and Geographic Availability

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

<table>
<thead>
<tr>
<th>MEDICAL APPOINTMENT ACCESS</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate access 24/7 or refer to ER or 911.</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 24 hours or refer to Urgent Care Center, ER or 911, as appropriate.</td>
</tr>
<tr>
<td>Non-Urgent (Symptomatic or chronic)</td>
<td>Within 72 hours</td>
</tr>
<tr>
<td>Routine / Preventive Care</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>Office Wait Time</td>
<td>Recommended not to exceed 15 minutes before taken to the exam room.</td>
</tr>
<tr>
<td>After Hours</td>
<td>All Covered Individuals shall have access to medical help or advice after business hours through their primary care physicians.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>BEHAVIORAL HEALTH APPOINTMENT ACCESS</th>
<th>MEASURE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency</td>
<td>Immediate access 24/7 - ER, 911 or crisis center.</td>
</tr>
<tr>
<td>Emergent - Non-Life Threatening</td>
<td>Within 6 hours or refer to crisis center, ER or 911, as appropriate.</td>
</tr>
<tr>
<td>Urgent</td>
<td>Within 48 hours or refer to crisis center, ER or 911, as appropriate.</td>
</tr>
<tr>
<td>Routine</td>
<td>Within 10 business days</td>
</tr>
<tr>
<td>After Hours Coverage</td>
<td>Emergency accessibility to a licensed clinician for consultation after hours 24/7. Covered Individual is referred to the on call practitioner, pager or cell phone.</td>
</tr>
<tr>
<td>Out of Office Coverage</td>
<td>Arrangement for coverage when you are unavailable via a pager, phone, another provider or on call physician.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>PROVIDER AVAILABILITY</th>
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<tbody>
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<td>MEDICAL NETWORK ADEQUACY</td>
</tr>
<tr>
<td>Commercial</td>
</tr>
<tr>
<td>OPEN PRACTICE</td>
</tr>
<tr>
<td>Note: Keep Anthem updated on open status.</td>
</tr>
</tbody>
</table>
GEOGRAPHIC AVAILABILITY OF MEDICAL PROVIDERS

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

<table>
<thead>
<tr>
<th>PROVIDER TYPE</th>
<th>MEASURE</th>
</tr>
</thead>
</table>
| • Primary Care Physicians: General and Family Practice (comb), Internal Medicine and Pediatrics. | • Two of each type within 5 miles (urban)  
• Two of each type within 12 miles (suburban)  
• Two of each type within 30 miles (rural) |
| • OB/Gyn                           | • One within 15 miles (urban)  
• One within 30 miles (suburban)  
• One within 40 miles (rural) |
| • Specialists                      | • Minimum of one of each major specialty within 30 miles |
| • Hospitals                        | • One within 30 miles or 30 minutes |
| • Skilled Nursing Facility         | • One within 30 miles or 30 minutes |

BEHAVIORAL HEALTH NETWORK ADEQUACY

Commercial

GEOGRAPHIC AVAILABILITY OF BEHAVIORAL HEALTH PROVIDERS

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

Note: Guidelines apply to urban and rural areas where possible.

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

CULTURAL DIVERSITY

Practitioners meeting the needs and preferences of their patients

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

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

- This Toolkit for Caring for Diverse Populations is organized into several sections. Each contains background information and tools that can be printed for use in the office.

  http://bridginghealthcaregaps.com

- Practitioners can provide Anthem with their gender and race/ethnicity for the provider directory via the Provider Maintenance Form (PMF) at anthem.com. [state] Answers@Anthem / Provider Maintenance Form / Section C. This information will be utilized in online provider directories available to your customers.

Covered Individuals’ Rights and Responsibilities

To better educate Covered Individuals and clients in their roles as consumers of health care services, Anthem has developed a Covered Individuals' Rights and Responsibilities policy for all Health Benefit Plans that Anthem administers. The policy is provided to all new Covered Individuals upon enrollment through the Health Benefit Plan. It is also published annually in the Covered Individual newsletter, is available on the web site, and in provider directories. The policy is also provided to new Network/Participating Providers via Anthem.com, in hard copy via this provider manual, and is also located in the provider directories.

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Rights

Covered Individuals have the right to:

- Receive information about the organization and its services, practitioners and providers, and Covered Individuals’ rights and responsibilities.
- Be treated respectfully, with consideration and dignity.
- Receive all the benefits to which they are entitled under their Health Benefit Plan.
- Obtain from their provider complete information regarding their diagnosis, treatment, and prognosis in terms they can reasonably understand.
- Receive quality health care through their provider in a timely manner and a medically appropriate setting.
- Participate with their provider in making decisions about their health care treatment.
- Have a candid discussion with their provider about treatment options, regardless of cost or benefit coverage.
- Refuse treatment and be informed by your provider of the medical consequences.
- Receive wellness information to help you maintain a healthy lifestyle.
- Express concerns and complaints about the care and services you received from a Provider or the service you received from Anthem, and to have Anthem investigate and take appropriate action.
- Have confidentiality and privacy.
- Make recommendations regarding the organization’s rights and responsibilities policies.
- Designate or authorize another party to act on your behalf, regardless of whether you are physically or mentally incapable of providing consent.

Responsibilities

Covered Individuals have the responsibility to:

- Understand their health issues and be wise consumers of health care services.
- Select or use providers who will provide or coordinate their total health care needs, and to maintain an ongoing patient-physician relationship with that physician.
- Provide complete and honest information we need to administer benefits and providers need to care for them.
- Follow the treatment plan and instructions for care that the Covered Individual and the provider have developed and agreed upon; understand how to access care in routine, urgent, and emergency situations; know their benefits as they relate to out-of-area coverage, coinsurance, copayments, etc.; and to notify their provider or Anthem about concerns you have regarding the services or medical care they receive.
- Be considerate of other Covered Individuals, providers, and Anthem’s staff.
- Read and understand their Health Benefit Plan and other materials from Anthem concerning coverage.
- Provide accurate and complete information to Anthem about other health care coverage and/or insurance benefits they may carry.
- Understand their health problems and to participate in developing mutually agreed-upon treatment goals to the degree possible.
- Keep appointments for care and give reasonable notice of cancellations.
- Inform Anthem of changes to their name, address, phone number, additions or removals of dependents or changes to their Primary Care Physician.

Open Practice

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

Insurance Requirements

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

1. Professional liability/medical malpractice liability insurance with limits of not less than $1,000,000 per claim and $3,000,000 in the aggregate which shall pay for claims arising out of acts, errors or omissions in the rendering or failure to render the services to be obtained under this Agreement. However, employees of a federal, state or local governmental agency shall instead be required to maintain the professional liability policies; CompCare Health Services Insurance Corporation (“CompCare”), which underwrites or administers the HMO policies; and CompCare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. © April, 2013 Blue Cross Blue Shield of Wisconsin
insurance, if any, required by law. 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, Network/Participating Provider agrees to furnish and maintain an extended period reporting endorsement ("tail policy") for the term of not less than three (3) years in the amount not less than the per claim and aggregate values indicated above. Professional liability/medical malpractice limits may be satisfied with a combination of primary and excess coverage. Additionally, in states with patient compensation funds, a Network/Participating Provider may have less insurance coverage if the patient compensation fund, when considered with Network/Participating Provider’s insurance and any applicable limits on damage awards, provides equivalent coverage.

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

3. Commercial general liability insurance for Facilities 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. (These commercial general liability limits are encouraged for professional providers, as well);

B. Self-Insurance can be in the form of a captive or self-management of a large retention through a Trust. A self-insured Network/Participating Provider shall maintain and provide evidence 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. Designated professional liability or medical malpractice defense firm(s);
4. Excess insurance/re-insurance above self insured layer; self insured retention and insurance combined must meet minimum limit requirements; and
5. Evidence of surety bond, reserve or line of credit as collateral for the self-insured limit.

C. Network/Participating Provider 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 request.

Wisconsin Autism Mandate

Wisconsin statute 632.895 (12m) requires that insurers cover evidenced-based therapy services for individuals with autism spectrum disorders (autism disorder, Asperger’s syndrome and pervasive developmental disorder not otherwise classified) when provided by certain qualified providers. The autism mandate was effective November 1, 2009, and applies to policies sold or renewed on or after that date. The Office of the Commissioner of Insurance has issued regulations interpreting the statute, which can be found at Wisconsin Administrative Code INS 3.36.

Senate Bill 667 adds insurance coverage for the services of board-certified behavior analysts (BCBA) for autism treatment to the state’s autism coverage mandate effective May 12, 2010. It also establishes state licensing and regulation of BCBAs by the Department of Regulation and Licensing.

Mandate Requirements
Insurers are required to cover:

1. Intensive-level services
   - Definition: Evidenced-based behavioral therapy. On average, behavioral therapy should be provided for at least 20 hours per week. Treatment plans are required to be created and updated by the treating providers.
   - Coverage Provided: $50,000 annually for up to 4 years*
   - Age Requirements: Begins after 2 years of age and before 9 years of age
   - Anthem BlueCross and BlueShield (Anthem) Billing Recommendation: CPT 97532 with an autism diagnosis (299.0, 299.00, 299.01, 299.8, 299.80, 299.81, 299.9, 299.90, 299.91)

2. Non-intensive therapy
   - Definition: Evidence-based therapy that will improve the individual’s condition. Treatment plans are required to be created and updated by the treating providers.
   - Coverage Provided: $25,000 annual maximum*
     - Covered when intensive therapy is completed, or

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In cases where an individual will not receive intensive therapy

- **Age Requirements:** none
- **Anthem Billing Recommendation:** Bill the appropriate code for the services provided with an autism diagnosis (299.0, 299.00, 299.01, 299.8, 299.80, 299.81, 299.9, 299.90, 299.91)

### Autism Provider Requirements

The therapy must be prescribed by a physician and provided by a psychiatrist, psychologist, licensed clinical social worker, outpatient mental health clinic, occupational therapist or speech therapist, board-certified behavior analyst, or a paraprofessional working under the supervision of a qualified psychiatrist, psychologist or licensed clinical social worker. These providers must meet certain training requirements in order to be considered qualified providers.

To verify that the provider is a qualified provider, Anthem requires that providers complete a form certifying their qualifications. Specialty-specific forms are posted on the Provider Forms page on Anthem.com and listed below:

- Psychiatrist, Psychologist, Behavioral Analyst or Licensed Clinical Social Worker Certification Form For Intensive Level Services
- Psychiatrist, Psychologist, Behavioral Analyst or Licensed Clinical Social Worker Certification Form For Non-Intensive Level Services
- Outpatient Mental Health Clinic Certification Form
- Autism Paraprofessional Certification Form (completed by supervising provider)
- Occupational Therapist and Speech Therapist Certification Form

Claims submitted for the autism treatment described in this section by providers who have not returned the applicable completed form(s) to Anthem may be denied as non-covered services; but may be adjusted once a completed form is received. Please contact Provider Service with questions regarding claim denials.

### Services Not Covered Under the Mandate

The following services are not covered:

- Acupuncture
- Animal-based therapy including hippotherapy
- Auditory integration training
- Chelation therapy
- Child care fees
- Cranial sacral therapy
- Custodial or respite care
- Hyperbaric oxygen therapy
- Special diets or supplements
- Sensory integration therapy (considered to be an investigational service by Anthem)

This is a short summary of the autism mandate statute and regulation. You are encouraged to read the regulation thoroughly so you understand what providers must comply with in order for services to be covered by this mandate.

**Links to Statute and Regulation**

- [http://www.legis.state.wi.us/statutes/Stat0632.pdf](http://www.legis.state.wi.us/statutes/Stat0632.pdf)

*Federal Mental Health Parity may eliminate these caps for large employer health plans.*

**Dispute Resolution and Arbitration**

The substantive rights and obligations of Anthem and Network/Participating Provider with respect to resolving disputes are set forth in the Anthem Facility Agreement (the "Agreement") or the Anthem Provider Agreement (the "Agreement"). The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. **Cost of Non-binding Mediation**
The cost of the non-binding mediation itself will be shared equally between the parties, except that each party shall bear the cost of its attorney's fees.

B. Location of the Arbitration

The arbitration will be held in the city and state in which the Anthem office identified in the address block on the signature page to the Agreement is located except to the extent both parties agree in writing to hold the arbitration in some other location.

C. Selection and Replacement of Arbitrator(s)

For disputes requiring a three (3) arbitrator panel under the terms of Article VII of the Agreement, then the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Network/Participating Provider, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

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

E. Decision of Arbitrator(s) and Cost of Arbitration

The decision of the arbitrator, if a single arbitrator is used, or the majority decision of the arbitrators, if a panel is used, shall be binding. The arbitrator(s) may construe or interpret, but shall not vary or ignore, the provisions of this Agreement and shall be bound by and follow controlling law (except to the extent the Agreement lawfully requires otherwise, as in the case of the period of limitations). The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56. The cost of any arbitration proceeding under this section shall be shared equally by the parties to such dispute unless otherwise ordered by the arbitrator(s); provided, however, that the arbitrator(s) may not require one party to pay all or part of the other party's attorneys' fees. Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

F. Confidentiality

All statements made, materials generated or exchanged, and conduct occurring during the arbitration process, including but not limited to materials produced during discovery, arbitration statements filed with the arbitrator(s), and the decision of the arbitrator(s), are confidential and shall not be disclosed in any manner to any person who is not a director, officer, or employee of a party or an arbitrator or used for any purpose outside the arbitration.
Provider Services, Network Relations and Contracting

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

Contact a Provider Service Representative by calling the Provider Inquiry Department at (888) 571-9055 or the phone number provided on the back of the Covered Individual’s identification card (“ID”) for questions/comments concerning:

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

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

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

Provider Directory

The provider directory is available on our website at www.anthem.com. If you do not have internet access and would like to receive a current provider directory please contact the Provider Inquiry Department.

Anthem Provider Web Site

www.Anthem.com

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

Items that can be located on the Provider Home Page:

- Self Service and Support
  - Customized Claim Edits
  - Medical Policies and Clinical UM Guidelines
  - Behavioral Health Provider Resources
  - Credentialing
  - Cultural and Linguistic Provider Resources
  - Electronic Data Interchange
  - Electronic Self-Service Options
  - Precertification (Tools and Resources)
  - Precertification Guidelines
  - Provider Maintenance Form
- Our Plans & Benefits
- Health and Wellness
  - Practice Guidelines
  - Tools and Resources for Providers
- Communications
  - Publications
  - General Information
  - Health Care Reform and Notifications
  - ICD-10
  - Network eUpdates
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MyAnthem®
MyAnthem is the secured section of the provider web portal. (Requires registration, and a user id and password.)

Functions that can be performed on MyAnthem:

- Fee Inquiry
- Professional and Facility Reimbursement Policies
- AIM Specialty Health℠
- OptiNet Survey
- Remittance Inquiry
- Anthem® Care Comparison

Availity®
Availity is offering 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** – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL members, including BlueCard® and FEP.
- **Claim status inquiry** – See details and payment information including claim line-level details/processing.
- **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.
- **Secure Messaging** – Send a question to clarify the status of a claim or to get additional information on claims.
- **AIM Specialty Health℠ (AIM)** – link to precertification requests and inquiries through AIM.
- **Member Certificate Booklet** – View a local plan member’s certificate of coverage, when available.
- **Online Remits** – Link to Anthem online remits under Claims Management/Remittance Review.

*Anthem-specific products that can be accessed through Availity require continued registration on MyAnthem℠.

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](http://www.availity.com) for a full list of payers.)

• **Compliance** – Availity is compliant with all Health Insurance Portability and Accountability Act (HIPAA) regulations.

**How to get started**

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

Once you log into the 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.**

**For an online demonstration or to register for access to the Availity Health Information Network, visit** [www.availity.com](http://www.availity.com)

---

**Claims Submission**

**Service Area**


**Illinois counties:** Boone, Jo Daviess, Lake, McHenry, Stephenson; Winnebago.

**Iowa counties:** Allamakee, Clayton, Dubuque;

**Michigan counties:** Dickinson, Gogebic, Iron, Menominee

**Minnesota counties:** Carlton, Chisago, Dakota, Goodhue, Houston, Pine, St. Louis, Wabasha, Washington, Winona.
**Claim Filing Tips**

Eliminate processing delays and unnecessary correspondence with these Claim filing tips.

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

**Claim Filing**

- Submit all paper Claims using the standard RED CMS-1500 Claim form for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- Do not highlight any fields on the CMS-1500 or UB-04 (CMS-1450), as it makes it more difficult to create a clear electronic copy.
- Do not use a DOT matrix printer, which is difficult to read.
- Check the printing of your Claims from time to time to help ensure proper alignment and that characters are easy to read.
- Make sure all characters are inside the field and that they do not overlap the lines.
- Changing the printer cartridge regularly is also helpful.
- Include the entire prefix and Covered Individual ID number in field 1a on all pages of the CMS-1500 Claim form.
- Include the referring provider’s name in field 17 of the CMS-1500 Claim form, if applicable.
- Providers will avoid having their Claims returned for correction by ensuring they are placing their national provider identifier ("NPI") number in the correct boxes, and ensuring that the information in a box on the Claim form does not overlap another box. (As a reminder, the NPI is reported in 17b, 32a, and/or 33a as applicable.)
- Include the rendering Provider NPI in 24J Lower of the CMS-1500 Claim form, e.g.: NPI.
- Include the following provider information listed in field 33 for the CMS-1500 Claim form: Provider Name, Address, Zip Code, and NPI.
- All multiple page Claims must be submitted with provider information in fields 32 and 33 printed on all pages of the CMS-1500 Claim form.
- Complete all mandatory fields on the CMS-1500 and UB-04 (CMS-1450).

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

<table>
<thead>
<tr>
<th>Type of Care/Claim</th>
<th>Records Required</th>
</tr>
</thead>
<tbody>
<tr>
<td>BiPap</td>
<td>• History &amp; Physical (&quot;H&amp;P&quot;)</td>
</tr>
<tr>
<td></td>
<td>• Office notes</td>
</tr>
<tr>
<td></td>
<td>• Sleep study results</td>
</tr>
<tr>
<td></td>
<td>• Prescription for BiPap</td>
</tr>
<tr>
<td></td>
<td>• Documentation of failed CPAP trial</td>
</tr>
<tr>
<td>Type of Care/Claim</td>
<td>Records Required</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Breast Reduction</td>
<td>• Recent H &amp; P and initial evaluation&lt;br&gt;• Office notes&lt;br&gt;• Documentation of all previous conservative treatment&lt;br&gt;• Operative report indicating amount of tissue removed from each breast&lt;br&gt;• Pathology report&lt;br&gt;• Presenting symptoms and their duration&lt;br&gt;• Covered Individual's height and weight – Body Mass Index (“BMI”)&lt;br&gt;• Do not send photos unless specifically requested by Anthem</td>
</tr>
<tr>
<td>Cardiac Rehab</td>
<td>• Start of care date for the cardiac rehab program&lt;br&gt;• Daily breakdown of charges&lt;br&gt;• Date of onset and nature of recent cardiac event&lt;br&gt;• All therapy records&lt;br&gt;• Supporting documentation why program exceeded the 12-week/36-session limit if applicable</td>
</tr>
<tr>
<td>DME</td>
<td>• Recent H &amp; P and initial evaluation&lt;br&gt;• Office notes&lt;br&gt;• MD order&lt;br&gt;• Therapy and progress notes&lt;br&gt;• Manufacturer’s description and model number</td>
</tr>
<tr>
<td>Growth Hormone</td>
<td>• Recent H &amp; P and initial evaluation&lt;br&gt;• Office notes&lt;br&gt;• Therapy and progress notes&lt;br&gt;• Treatment protocol&lt;br&gt;• Growth hormone (“GH”) stimulator tests results&lt;br&gt;• Recent X-ray report (not films) that shows status of epiphyses&lt;br&gt;• Recent growth chart including documented percentile of height for age including number of standard deviations below the mean</td>
</tr>
<tr>
<td>Not Otherwise Classified</td>
<td>• Complete, specific description of procedure/service/Durable Medical Equipment (“DME”)/drug&lt;br&gt;• Manufacture’s description and model number for DME&lt;br&gt;• If the item is a rental item, include the purchase price.&lt;br&gt;• If the NOC is for a drug, include the drug’s name, dosage NDC number and number of units.&lt;br&gt;• If NOC code is for a surgical procedure, include the operative report.&lt;br&gt;• Medical records to support the changes for the NOC code including documentation to support medical necessity of the item or service&lt;br&gt;• If NOC is for an office procedure, include office notes for the date of service for which the NOC code was billed.</td>
</tr>
<tr>
<td>Sclerotherapy or treatment of varicose veins</td>
<td>• Recent H &amp; P and initial evaluation&lt;br&gt;• Office notes&lt;br&gt;• Documentation of all previous conservative treatments, including length of treatments tried&lt;br&gt;• Doppler study result&lt;br&gt;• Complete, specific description of surgical procedure performed</td>
</tr>
<tr>
<td>Synagis</td>
<td>• Recent H &amp; P and initial evaluation&lt;br&gt;• Office notes&lt;br&gt;• Gestational age at birth&lt;br&gt;• Documentation of all specific risk factors present</td>
</tr>
</tbody>
</table>
Recommended Fields for CMS 1500

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

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

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

Field 3: Patient’s Birth Date – date of birth should be mmddyy.

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

Field 6: Patient Relationship to Insured

Field 7: Insured’s Address

Field 10: Is Patient’s Condition Related to:

Field 10A: Employment?

Field 10B: Auto Accident?

Field 10C: Other Accident?

Field 14: Date of Current – illness, injury or pregnancy (if applicable).

Field 17a: Referring physician PIN

Field 17b: Referring physician NPI

Field 21: Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature.

Field 24A: Date(s) of Service

Field 24B: Place of Service

Field 24D: Procedures, Services or Supplies – enter the appropriate CPT code/nomenclature; include a narrative description for NOC codes. Do not use NOC codes unless there is no specific CPT code available. Please indicate appropriate modifier when applicable.

Field 24E: Diagnosis Pointer – refer to field 21.

Field 24F: $ Charges – line item charge.

Field 24G: Days or Units - When providing anesthesia submit time in minutes. When providing pain management, drugs, etc. it should be submitted in units.

Field 24J: Upper: Rendering Provider ID # - Provider Identification Number (PIN) (except entities that do not have individual rendering physician NPIs associated with them.)

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

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

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

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

Field 32: Service Facility Location Information
Field 32a: Providers National Provider Identification number (NPI)
Field 32b: Provider Identification Number (PIN)
Field 33: Billing Provider Information and Phone #
Field 33a: Physician’s National Provider Identification number (NPI)
Field 33b: Provider Identification Number (PIN)
**Health Insurance Claim Form**

**Approved by National Uniform Claim Committee 05/05**

<table>
<thead>
<tr>
<th>Field</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a. Insured's I.D. Number</td>
<td>(For Program in Item 1)</td>
</tr>
<tr>
<td>2. Patient's Name</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>3. Patient's Birth Date</td>
<td>(MM DD YY)</td>
</tr>
<tr>
<td>4. Insured's Name</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>5. Patient's Address</td>
<td>(No., Street)</td>
</tr>
<tr>
<td>6. Patient Relationship to Insured</td>
<td>(Self, Spouse, Child, Other)</td>
</tr>
<tr>
<td>8. Patient's Status</td>
<td>(Single, Married, Other)</td>
</tr>
<tr>
<td>9. Other Insured's Name</td>
<td>(Last Name, First Name, Middle Initial)</td>
</tr>
<tr>
<td>10. Insured's Condition Related To</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>a. Employment</td>
<td>(current or previous)</td>
</tr>
<tr>
<td>b. Auto Accident</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>c. Employer's Name or School Name</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>d. Is There Another Health Benefit Plan?</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>e. Other Accident</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>11. Insured's Policy Group or FECA Number</td>
<td>(yes or no)</td>
</tr>
<tr>
<td>12. Patient's or Authorized Person's Signature</td>
<td>(I authorize the release of medical or other information necessary to process this claim.)</td>
</tr>
<tr>
<td>13. Insured's or Authorized Person's Signature</td>
<td>(I authorize payment of medical benefits to the undersigned physician or supplier for services described below.)</td>
</tr>
<tr>
<td>14. Date of Service</td>
<td>(MM DD YY)</td>
</tr>
<tr>
<td>15. If Patient Has Had Same or Similar Illness</td>
<td>Give First Date (MM DD YY)</td>
</tr>
<tr>
<td>16. Dates Patient Unable to Work in Current Occupation</td>
<td>From (MM DD YY) to (MM DD YY)</td>
</tr>
<tr>
<td>17. Name of Referring Provider or Other Source</td>
<td>(17a. F.)</td>
</tr>
<tr>
<td>18. Reserved for Local Use</td>
<td>(17b. NPI)</td>
</tr>
<tr>
<td>21. Diagnosis or Nature of Illness or Injury</td>
<td>(Relate Items 1, 2, 3 or 4 to Item 34E by Line)</td>
</tr>
<tr>
<td>22. Medicaid Resubmission Code</td>
<td>(Original Ref. No.)</td>
</tr>
<tr>
<td>23. Prior Authorization Number</td>
<td>(NPI)</td>
</tr>
<tr>
<td>24. A. Dates of Service</td>
<td>(MM DD YY)</td>
</tr>
<tr>
<td>B. X-ray or Service</td>
<td>(NPI)</td>
</tr>
<tr>
<td>C. Procedures, Services, or Supplies (explain unusual circumstances)</td>
<td>(NPI)</td>
</tr>
<tr>
<td>D. Modifier</td>
<td>(NPI)</td>
</tr>
<tr>
<td>E. Diagnosis</td>
<td>(NPI)</td>
</tr>
<tr>
<td>F. $ Charges</td>
<td>(NPI)</td>
</tr>
<tr>
<td>G. Days of Service</td>
<td>(NPI)</td>
</tr>
<tr>
<td>H. Payment/Coverage</td>
<td>(NPI)</td>
</tr>
<tr>
<td>I. Qual.</td>
<td>(NPI)</td>
</tr>
<tr>
<td>J. Rendering Provider ID #</td>
<td>(NPI)</td>
</tr>
<tr>
<td>25. Federal Tax I.D. Number</td>
<td>(SSN, BIN)</td>
</tr>
<tr>
<td>26. Patient's Account Number</td>
<td>(NPI)</td>
</tr>
<tr>
<td>27. Accept Assessment?</td>
<td>(Yes or No)</td>
</tr>
<tr>
<td>28. Total Charge</td>
<td>(NPI)</td>
</tr>
<tr>
<td>29. Amount Paid</td>
<td>(NPI)</td>
</tr>
<tr>
<td>30. Balance Due</td>
<td>(NPI)</td>
</tr>
<tr>
<td>31. Signature of Physician or Supplier</td>
<td>(including degrees or credentials) (I certify that the statements on the reverse apply to this bill and are made in part thereof.)</td>
</tr>
<tr>
<td>32. Service Facility Location Information</td>
<td>(NPI)</td>
</tr>
<tr>
<td>33. Billing Provider Info &amp; PH #</td>
<td>(NPI)</td>
</tr>
</tbody>
</table>

**Signed**

NUCC Instruction Manual available at: www.nucc.org

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Recommended Fields for UB-04 (CMS-1450)

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

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

Field 4: Type of Bill
Field 5: Fed. Tax No.
Field 6: Statement Covers Period
Field 8: Patient Name
Field 9: Patient Address
Field 10: Birthdate
Field 11: Sex
Field 12: Admission Date
Field 13: Admission HR
Field 14: Admission Type
Field 15: Admission SRC
Field 16: D HR
Field 17: STAT
Fields 31 - 34: Occurrence Codes and Dates
Field 42: Rev. Cd.
Field 44: HCPCS/Rates/HPPS Code
Field 45: Serv. Date
Field 46: Serv. Units
Field 47: Total Charges
Field 56: Providers National Provider Identification number (NPI)
Field 59: Patient's Relationship
Field 60: Insured Unique ID – from Covered Individual ID card, including any prefix/suffix
Field 67: Principal Diagnosis Code
Fields 67A - Q: Other Diagnosis Codes
Field 74: Principal Procedure Code and Date 7 - For use in Indiana, Kentucky, Missouri, Ohio and Wisconsin
For Outpatient UB-04 (CMS-1450) Claim form, these fields must be completed:

Field 4: Type of Bill
Field 6: Statement Covers Period
Field 8: Patient Name
Field 9: Patient Address
Field 10: Birth date
Field 12: Admission Date
Field 13: Admission HR
Fields 31 - 34: Occurrence Codes and Dates
Field 42: Rev. Cd.
Field 44: HCPCS/Rates/HPPS Code
Field 45: Serv. Date
Field 46: Serv. Units
Field 47: Total Charges
Field 56: Providers National Provider Identification number (NPI)
Field 59: Patient’s Relationship
Field 60: Insured’s Unique ID – from Covered Individual ID card, including any prefix/suffix
Field 67: Principal Diagnosis Code
Fields 67A - Q: Other Diagnosis Code
Field 74: Principal Procedure Code
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Electronic Data Interchange ("EDI")

Electronic Data Interchange (EDI) allows providers to submit and receive electronic transactions from their computer systems. EDI is available for most common health care business transactions, such as:

- 837 Health Care Claim Professional
- 837 Health Care Claim: Institutional
- 835 Health Care Claim Payment/Remittance Advice
- 270/271 Health Care Eligibility Benefit Inquiry and Response
- 276/277 Health Care Claim Status Request and Response
- 278 Health Care Services Review – Request for Review and Response

Anthem is Health Insurance Portability and Accountability Act ("HIPAA") compliant and a strong proponent of EDI transactions because they will significantly reduce administrative and operating cost, gain efficiency in processing time and improve data quality. Under HIPAA, as EDI transactions gradually replace paper-based transactions, the risk of losing documents, encountering delays, and paper chasing is minimized.

The EDI section of this provider manual includes information needed to begin and increase the transactions your office is submitting electronically. Visit our online resources to learn more about the services and electronic filing options mentioned in this guide.

Online EDI Resources & Contact Information

At Anthem, we've dedicated a website to share electronic information with you or your EDI vendors (clearinghouses, software vendors and billing agencies). Our website gives you pertinent and timely information, along with helpful tools to ease electronic transactions.

To access all EDI manuals, forms and communications listed below, go to www.Anthem.com/edi and select state.

Find detailed answers in the Anthem HIPAA Companion Guide. The HIPAA Companion Guide has the details on how to submit, receive and troubleshoot electronic transactions required by HIPAA.

Whether you submit directly to us or use a clearinghouse, software vendor or billing agency, the HIPAA Companion Guide and the HIPAA Implementation Guide are effective tools to help address your questions. The more you understand how we process electronic transactions, the better your experience with electronic transactions will be — even if you use an outside service.

What you’ll find online:

- EDI registration information and forms
- EDI contacts and support information
- EDI communications and electronic submission tips
- Information on electronic filing benefits and cost-savings
- Online tools for submitting electronic CMS-1500 Claims directly to us
- Filing instructions for EDI submission of eligibility, benefit and Claim status inquiries
- Anthem HIPAA Companion Guide with complete information on submitting and receiving electronic transactions
- Anthem report descriptions
- List of clearinghouses, software vendors and billing agencies
- FAQ's and answers about electronic transactions
- Information and links pertaining to HIPAA
- Contractual agreements with our trading partners

You will find answers to the most frequently asked questions about submission options, connectivity, troubleshooting tips, contact information and much more.
Contacting the EDI Solutions Helpdesk

For more information about electronic Claims filing, electronic remittance advice, eligibility benefit inquiry, Claim status and other transactions, call Anthem EDI Solutions Helpdesk for details. Our Help Desk can address questions regarding connectivity, registration, testing and the implementation process.

Business hours: 8:00 a.m.-5:30 p.m. Eastern
Monday-Friday
Phone: 800-470-9630
Fax: 502-889-4533
E-mail: anthem.edi@anthem.com
Website/Live Chat: www.Anthem.com/edi>Select State

Live Chat is an instant messaging service where EDI Solutions Help Desk specialists are available to answer questions from our customers.

Submitting & Receiving EDI Transactions

Visit our web site www.Anthem.com/edi for enrollment, approved Anthem vendor listing or refer to our HIPAA Anthem Companion Guide for complete instructions on how to send and receive these and other transactions electronically.

Select EDI Submission Approach

The transactions associated with EDI Submission are:

- 837 Health Care Claim: Professional, or
- 837 Health Care Claim: Institutional

Providers and Facilities must manage their own unique set of marketplace requirements, operational needs, and system capabilities. Two basic methods are available to generate EDI transactions:

- Direct Submission by Provider
- Submission by Clearinghouse or Billing Service

Direct Submission by Provider

Under the direct submission approach, the trading partner is the provider or Facility. The provider or Facilities' internal programming staff or systems vendor modifies the computer system to meet the format and quality requirements of the ASCX12N HIPAA Implementation Guides and Anthem Companion Guide. The responsibility of operating the computer, modem, communications software, and data compression software also lies with the staff or vendor.

Submission by Clearinghouse or Billing Service

Under the submission by Clearinghouse or Billing Service approach, the clearinghouse or Billing Service is the Trading Partner. Services are paid by the provider or Facility for the EDI preparation, submission, and/or practice management. The business relationship between the Trading Partner and office or Facility is held strictly between the two parties. Typically, the Clearinghouse will help you configure the necessary computer equipment or billing software.

Troubleshooting Electronic Submissions

How do I know when to contact Anthem or my clearinghouse and/or vendor?

Direct Submitters: having technical difficulties, problems with reports or any other related issues to electronic transactions (1) contact your designated customer support center, if further directed to Anthem (2) contact EDI Solutions Helpdesk. With reports, password re-set or any other related issues to electronic transactions

Clearinghouse or Vendor Submitters: having technical difficulties with electronic transactions contact your designated customer service support center.
Make the Most of Your Electronic Submissions Coordination of Benefits (COB)

Effective with HIPAA, Anthem has the capability to accept secondary/coordination of benefits ("COB"), electronically. One of the benefits of the electronic Claim format (837) required by HIPAA is its COB capability without using paper Claims or copies of Explanation of Benefits ("EOB").

Anthem encourages providers and Facilities to maximize their investment in electronic submission and contact your clearinghouse or vendor to help determine what, if any, changes are required and how to get started.

Visit our website www.Anthem.com/edi and refer to our Anthem HIPAA Companion Guide on how to file these and other transactions electronically.

Medicare Crossover Claims

Ensure crossover Claims are forwarded appropriately, remember to always include:

- Complete Health Insurance Claim Number ("HICN")
- Covered Individual's complete ID number, including the three (3) character alpha prefix
- Covered Individual's name as it appears on the patient's ID card, for supplemental insurance

Reduce Duplicate Billing:

- Do not file with us and Medicare simultaneously.
- Wait until you receive the Explanation of Medical Benefits ("EOMB") or payment advice from Medicare.
- Payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued, CMS requests that you do not bill your patients' supplemental insurers for a minimum of fifteen (15) work days after receiving the Medicare payment.

After you receive the Medicare payment advice/EOMB, determine if the Claim was automatically crossed over to the supplemental insurer. If the Claim was crossed over, the payment advice/EOMB should typically have “Remark Code MA 18” printed on it, which states, “The claim information is also being forwarded to the patient's supplemental insurer. Send any questions regarding supplemental benefits to them.” The code and message may differ if the contractor does not use the ANSI X12 835 payment advice. If the Claim was crossed over, do not file for the Medicare supplemental benefits.

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

EDI Reports Speed Account Reconciliation

Electronic transactions produce an immediate acknowledgement report from Anthem, a virtual receipt of your Claims. You will also receive a response report listing Claim detail and initial entry rejections, which can immediately be corrected and resubmitted.

Timely reporting lets you quickly correct errors so you can re-submit electronic transactions quickly — speeding account reconciliation. The two-stage process, outlined below, must be closely monitored. Please implement ways to monitor submissions and reconcile errors with electronic transmissions during these stages. If you work with an EDI vendor, clearinghouse or billing agency, it’s your responsibility to ensure reports are accurate, flexible, clear and easy to understand. Additionally, please ensure your office staff gets appropriate training on report functions.

You can find Anthem report descriptions, along with formatting specifications, error listings and troubleshooting tips online at www.Anthem.com/edi or in our Companion Guide.

Stage 1: EDI Reconciliation — Provider’s Office/Facility to EDI Vendor

Stage 2: EDI Reconciliation — EDI Vendor to Payer

Report Basics

- Work reports each day, ensuring prompt handling of Claims
- Reconcile both Claim totals and dollars
• Correct Claims with errors and resubmit them electronically to provide an audit trail and to avoid payment delays
• Work with EDI vendors to ensure Anthem reports are available. Our reports are your receipt that Claims were either accepted for processing or rejected due to errors.
• If you use an EDI vendor, you should work with them directly if there are questions about data content, delivery times frames, formatting or errors

Electronic Remittance Advice (ERA)

The transaction associated with ERA is:
• 835 Health Care Claim Payment/Remittance Advice

Anthem offers secure electronic delivery of remittance advices, which explain Claims in their final status. This is an added benefit to our electronic Claim submitters. If you are an electronic Claims submitter and currently receive paper remits, contact EDI Solutions Helpdesk today to enroll for electronic remits.

Reduce accounts receivable days and administrative expenses by taking advantage of automated posting options often available with an electronic remittance. The content on the Anthem remittance advice meets HIPAA requirements, containing nationally recognized HIPAA compliant remark codes used by Medicare and other payor’s like Anthem.

How to enroll for ERA

Download the ERA enrollment form our web site or refer to the 835 HIPAA Companion Guide for additional details.

If you use an EDI vendor and/or clearinghouse, please contact their representative to discuss the electronic remittances. This will ensure that ERA enrollment procedures are followed appropriately with the vendor and with Anthem.

Changes after enrollment

It is very important that you notify us of any changes to your ERA request form both before and after enrollment. This includes any changes to your vendor, Tax Identification Number ("TIN"), billing address or bank account. Complete the ERA Request form found on our website.

Electronic Funds Transfer (EFT) overview

EFT is a safe, secure efficient process for directly depositing payments into your bank account. You’ll have immediate access to funds because banks process transactions through the Automated Clearinghouse ("ACH") network, the secure transfer system that connects all U.S. financial institutions. Providers who use EFT may notice the benefits listed below.

How to Enroll for EFT

Complete the EFT application attachment to the first paper remittance advice received each month or complete the EFT (Enrollment and Maintenance) Registration form found on our website.

Change After Enrollment

It is very important that you notify us of any changes to your EFT request form both before and after enrollment. This includes any changes to your vendor, TIN#, billing address or bank account. Complete the EFT (Enrollment and Maintenance) Registration form at anthem.com/edi.
Real Time Electronic Transactions

The Real Time transaction includes:
- 270/271 Health Care Eligibility Benefit Inquiry and Response, or
- 276/277 Health Care Claim Status Request and Response

Many health care organizations, including health care partners, payers, clearinghouses, software vendors and fiscal intermediaries offer electronic solutions as a fast, inexpensive and secure method of automating business processes.
- Allows providers and Facilities to perform online transactions
- Provides coverage verification before services are provided
- Includes detailed information for ALL Covered Individuals, including BlueCard.

Anthem has electronic solutions, giving provider’s access to patient insurance information before or at the time of service, using the system of their choice. Anthem is certified for Phase I and II of the Council for Affordable Quality HealthCare’s (“CAQH”) Committee on Operating Rules for Information Exchange (“CORE”).

Features

Eligibility benefit inquiry/response is a real time transaction that provides information on patient eligibility, coverage verification, and patient liability (deductible, co-payment, and coinsurance)

Claim status request and response is also a real time transaction that indicates whether an electronic Claim has been paid, denied or in progress.

Health care services review request and response is a real-time transaction used to advise Anthem of upcoming hospital stays and referrals to specialist.

Getting Connected with EDI Batch or Real time Inquires

- Clearinghouses and EDI vendors often have easy-to-use web and automated solutions to verify information for multiple payers simultaneously through one portal in a consistent format.
- Contact your EDI software vendor or clearinghouse to lean more about options available

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (“BCBSWI”), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (“Compcare”), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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Submission of Claims under the Federal Employee Health Benefit Program

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

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

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

Reimbursement and Administrative Policies

Attended Modalities and Therapeutic Procedures

Our policy regarding how to report units for physical therapy procedures and modalities is outlined below. For CPT-4 procedure codes 97032-97036, 97110-97124, 97140, 97530-97542, 97760-97762, we will reimburse a fifteen (15) minute unit of direct treatment service when the duration of direct treatment is greater than or equal to eight (8) minutes and less than twenty-three (23) minutes. Services rendered for seven (7) minutes or less should not be billed as a unit of service and may be subject to recovery upon audit. If the duration of a single modality or procedure is between twenty-three (23) minutes and less than thirty-eight (38) minutes, you may bill two fifteen (15) minute units.

Time intervals for larger numbers of units are as follows:

<table>
<thead>
<tr>
<th>Number of units billed:</th>
<th>Number of minutes provided in treatment:</th>
</tr>
</thead>
<tbody>
<tr>
<td>3 units</td>
<td>38 minutes - 52 minutes</td>
</tr>
<tr>
<td>4 units</td>
<td>53 minutes - 67 minutes</td>
</tr>
<tr>
<td>5 units</td>
<td>68 minutes - 82 minutes</td>
</tr>
<tr>
<td>6 units</td>
<td>83 minutes - 97 minutes</td>
</tr>
</tbody>
</table>

Note: If more than one modality or procedure is rendered during a calendar day, the total number of fifteen (15) minute units will be reimbursed based on the total direct treatment time for all modalities and/or procedures rendered.

This reimbursement policy is supported by the CMS guidelines for physical medicine and rehabilitation found in the National Correct Coding Policy Manual for Part B Medicare Carriers.

Blood, Blood Products, Processing, Storage and Administration

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

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

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

**Charge Master Data**

Hospitals will provide electronic submission of data to Anthem for evaluation of charge masters annually, or as requested by us, or thirty (30) days prior to the effective date of any charge master rate changes. This includes room rate changes.

This data should be in a format acceptable to Anthem. Data elements included in electronic submission should be CPT/HCPCS/Revenue Codes, procedure and service description codes, charge number, current price, previous price, departmental code, effective date and facility tax ID. These fields are not to be considered all-inclusive. After review of charge master data the hospital will work with us for any follow up evaluation and recuperation of funds if applicable.

**Coding Requirements**

Network/Participating Providers will submit Claims for all Health Services in accordance with current CMS coding requirements.

**Comprehensive Health Planning**

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

**Coordination of Benefits/Subrogation**

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

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

**Coordination of Benefits and the Federal Employee Health Benefit Program (“FEHBP”)**

In certain circumstances when the FEHBP is the secondary payor and there is no adverse effect on the Covered Individual, Anthem may take advantage of any provider discount arrangements the primary payor may have and
only make up the difference between the primary plan’s payment and the amount the provider has agreed to accept as payment in full from the primary plan.

**Courtesy Room**

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

**Daily Supply or One Time Charge Fees/Items**

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

**Different Settings Charges**

If Anthem determines that Network/Participating Provider submits charges differently for the same service performed in a different setting, Plan will reimburse the lesser of the two applicable Anthem Rates.

**Eligibility and Payment**

A guarantee of eligibility is not a guarantee of payment.

**Facility Personnel Charges**

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

**General Industry Standard Language**

Per Anthem policy and the contractual agreement, providers will follow industry standards related to billing. Examples of general industry standards include but are not limited to HCPCS, ICD9/CM, ICD10/CM, health service definition manual, or subsequent forms and CPT methodology.

**Instrument Trays**

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

**Interim Bill Claims**

Anthem shall not adjudicate Claims submitted as interim bills for services reimbursed under DRG methodology.
**IV Sedation - IV sedation and local anesthesia**

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

**Labor Care Charges**

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

**Mother/Baby Claims**

Facilities will submit, and Anthem will reimburse maternity Claims as two (2) separate and individual Claims according to the specified compensation schedule. Claims submitted for multiple births will be reimbursed per DRG for each birth and based on a single DRG for the mother.

**New Services**

At least sixty (60) days prior to the implementation of any new service during a Fiscal Year, hospitals will submit (1) a description of the service; (2) the proposed hospital charge, which will be reasonable compared to community norms for such charges, and reasonable in relation to the hospital’s cost of providing the new service; and (3) such other reasonable data and information required by Anthem to evaluate the new service. Within thirty (30) days after Anthem’s receipt of such data and information, we will provide the hospital with general coverage information regarding the new service. If hospital fails to provide the requested data or information relative to a new service on a timely basis, and we cannot complete our review of the proposed new service prior to hospital’s effective date of implementation, hospitals will withhold billing Anthem or a covered individual for the new service until the hospital is provided with the general coverage information, which shall be sent by Anthem within a reasonable time after Anthem has all the data and information necessary to evaluate the proposed new service. For any services added that do not meet the definition of new service in the provider’s contractual agreement, hospitals will: (1) establish a cost for the service which is reasonable compared to community norms; and (2) request Anthem’s review and general coverage information whenever the hospital is uncertain whether the service qualifies as a covered service.

**Network/Participating Provider Records**

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

**Nursing Procedures**

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

**Observation Room/Treatment Room Charges**

Anthem reimburses for observation room/treatment room charges up to twenty-four (24) hours of observation. Observation time begins with the arrival into the observation bed and ends with the order for discharge. Compensation for observation bed stay shall not exceed twenty-four (24) hours, nor shall it exceed the allowed compensation for an inpatient semi-private room and board rate. Facility will not be compensated for both Observation Charges and room and board fees on the same day.
Facilities will not bill Anthem and/or Covered Individuals and Anthem will not reimburse Facilities for the use or accommodation of treatment rooms for the provision of Health Services to a Covered Individual. Anthem will reimburse Facilities only for Covered Services provided to Covered Individuals in a treatment room as specified in the Agreement.

Non-Covered Use of Observation Beds

Services related to observation beds that are not reimbursable, include but are not limited to the following instances:
1. Services provided for the convenience of the physician, patient and/or family;
2. Services that are benefit exclusions;
3. Services rendered from the start of outpatient surgery until discharge from recovery room;
4. Services following routine diagnostic procedures such as endoscopies; and
5. Services not adequately supported by clinical documentation.

Observation Services, Proper Billing

Covered services submitted under Revenue Code 761 require a CPT/HCPCS code. The combined reimbursement for Revenue Code 760-769 will be limited to the approved semi-private room rate. All observation room/treatment room charges will be combined and limited to the approved semi-private room rate. Facilities will report observation charges under Revenue Code 762. CPT Codes are not required to be reported under Revenue Code 762. The only appropriate CPT Codes, if reported, are 99217 through 99220 and 99234 through 99236. Hospitals will report the number of hours the patient is in observation status in the units field. Any additional services performed while the patient is in observation status should be reported under the appropriate Revenue Code for those services.

Operating Room Time and Procedure Charges

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

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

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

Other Agreements Excepted

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

Overpayments Reimbursement

For purposes of this provider manual, overpayments reimbursement includes, but is not limited to, situations in which the Network/Participating Provider has been overpaid by Anthem due to an error in processing, an incorrect determination that the services were Covered, a determination that the Covered Individual was not eligible for services at the time services were rendered or another entity is primarily responsible for payment of the Claim. In those situations in which Network/Participating Provider issues a refund, such refund shall be made to Anthem within thirty (30) calendar days of Anthem’s request for reimbursement or thirty (30) calendar days of when Network/Participating Provider knew or reasonably should have known that Anthem was not liable or had otherwise overpaid the Claim, whichever is earlier.
**Personal Care Items**

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

**Pharmacy Charges**

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

**Portable Charges**

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

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

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

**Preparation (Set-Up) Charges**

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

**Present on Admission Indicator**

Present on admission (“POA”) indicators are required on electronic and paper Claim submissions from acute care Facilities. Valid values for the POA are:

- Y= Yes, condition was present at the time of inpatient admission
- N= No, condition was not present at the time of inpatient admission
- U= Unknown, the documentation is insufficient to determine if the condition was present at the time of inpatient admission
- W= Clinically Undetermined, the provider is unable to clinically determine whether the condition was present at the time of inpatient admission
- 1= Unreported/Not Used - Exempt from POA Reporting, Submitted in 4010A1 on electronic submissions, equivalent code of a blank field.

Acute Care Facilities shall include accurate and current CMS POA indicators on all inpatient Claims submitted to Anthem. Anthem will use such POA indicators and all other applicable and current CMS codes and conventions, as updated by CMS from time to time, to identify Preventable Adverse Events (“PAE”) and adjust inpatient payments to Facility made under the Agreement consistent with then-current CMS practices and DRG groupers.

**Preventable Adverse Events (“PAE”) Policy**

**Acute Care General Hospitals - PAE Policy**

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

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Covered Individual, the acute care general hospital shall neither bill, nor seek to collect from, nor accept any payment from the Health 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, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs.

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

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

**CMS Hospital Acquired Conditions ("HAC")**

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

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

**Network/Participating Provider (excluding Acute Care General Hospitals) – PAE Policy**

**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 Network/Participating Provider shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan or the Covered Individual for such events. If Network/Participating Provider 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, Network/Participating Provider shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid, below, occur with respect to a Covered Individual, Network/Participating Provider 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.
Preventable Adverse Event | Definition / Details
--- | ---
1. Surgery Performed on the Wrong Body Part | 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.
2. Surgery Performed on the Wrong Patient | Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.
3. Wrong surgical procedure performed on a patient | Any procedure performed on a patient that is not consistent with the documented informed consent for that patient. Excludes emergent situations that occur in the course of surgery and/or whose exigency precludes obtaining informed consent. Surgery includes endoscopies and other invasive procedures.
4. Retention of a foreign object in a patient after surgery or other procedure | Excludes objects intentionally implanted as part of a planned intervention and objects present prior to surgery that were intentionally retained.

Psychiatric Outpatient/Residential Services

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

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

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

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

Special billing instructions and requirements:

1. ICD-9 diagnosis codes must be included for each care level. The appropriate ICD-9 codes are 290.0 to 319.
2. Revenue codes must be included for each care level. Appropriate revenue codes are 0901, 0911-0914, 0944 or 0945.
3. Utilization management must approve the level of care for all services. An authorization number is required for each Claim.
4. Each service date must be billed as a separate line item.
5. Whole hours must be used to indicate hours of care in the “Service Units” field. Show whole hours in form locator 46.
Reimbursement for recovery room services (time or flat fee) includes all used and or available services, equipment, monitoring, nursing care that is necessary for the patient’s welfare and safety during his/her confinement. This includes, but is not limited to EKG monitoring, Dinamap®, pulse oximeter, injection fees, nursing, nursing time, nursing supervision, equipment and supplies, (whether disposable or reusable), defibrillator, and oxygen. Separate reimbursement for these services will not be made.

Reimbursement Methodologies

Case Rate Methodology

A Per Case Rate is an all-inclusive level of reimbursement for a specific inpatient or outpatient Covered Service, as specified by DRG, CPT/HCPCS/Revenue Code in the reimbursement section of the Anthem Agreement. Unless otherwise specified, no additional reimbursement shall be made for any covered service(s) submitted on the same Claim as a covered service reimbursed under Per Case Rate methodology.

Combination Emergency Room/Observation Services

The following provisions are applicable unless otherwise specified in your Agreement.

If a Covered Individual is admitted through the ER, OBS, or following SURG, Plan shall reimburse Facility according to the diagnosis and Anthem Rate associated with the Inpatient Services. Plan shall not reimburse Facility separately for the ER, OBS, and/or SURG.

If a Per Unit Rate, as set forth on the Rate Sheet, for such services as MRI, CT, or Mammogram, then such rate will be paid in addition to any other service or combination outlined below.

If ER, OBS and/or SURG services are provided during a single outpatient encounter and any such services are individually reimbursed as a Case Rate as specified in this PCS, Plan shall reimburse Facility as follows:

- **ER/OBS**: If a Case Rate has been negotiated for ER only, as set forth on the Rate Sheet, Plan shall reimburse Facility the ER Case Rate for the entire Claim.
- **ER/OBS**: If a Case Rate has been negotiated for OBS only, as set forth on the Rate Sheet, Plan shall reimburse Facility the OBS Case Rate for the entire Claim.
- **ER/SURG**: If a Case Rate has been negotiated for surgery, as set forth on the Rate Sheet, Plan shall reimburse Facility the SURG Case Rate for the entire Claim.
- **SURG/OBS**: If a Case Rate has been negotiated for surgery, as set forth on the Rate Sheet, Plan shall reimburse Facility the SURG Case Rate for the entire Claim.

For all other Claims, Plan shall reimburse Facility the surgery rate, as set forth on the Rate Sheet, for the entire Claim. There will be no additional reimbursement for other services, or as set forth on the Rate Sheet.

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Rate Sheet.

- SURG/ER/OBS: If a Case Rate has been negotiated for surgery, as set forth on the Rate Sheet, Plan shall reimburse Facility the SURG Case Rate for the entire Claim.

For all other Claims, Plan shall reimburse Facility the surgery rate, as set forth on the Rate Sheet, for the entire Claim. There will be no additional reimbursement for other services or as set forth on the Rate Sheet.

DRG Methodology

DRG means Diagnostic/Diagnosis Related Group as set forth by the CMS or other grouper as may be used by Anthem and updated as codes are updated.

DRG Rate means the all inclusive dollar amount applied to the appropriate DRG Weight which results in the Anthem Rate, if the reimbursement methodology as shown on the PCS reimbursement schedule is on a DRG basis.

DRG Weight means the computed value assigned to each DRG using CMS costweights.

For inpatient admissions on or after the Agreement effective date for which the total Facility charges for Covered Services is less than or equal to the DRG Outlier amount specified on the Reimbursement section of the Agreement, we will reimburse the DRG Rates specified in effect on the date of inpatient admission and specified on the reimbursement section of the Agreement multiplied by the weight for the assigned DRG in effect on the date of discharge, using the relative weights as established (and amended from time to time) by CMS.

For inpatient admissions on or after the Agreement effective date for which the total of Facility charges for Covered Services is greater than the DRG Outlier amount specified in the reimbursement section of the Agreement, we will reimburse the DRG Outlier Rate percentage as specified in the reimbursement section of the Agreement.

For inpatient admissions for Covered Individuals who are transferred out of the hospital to another Facility for purposes of providing Inpatient Covered Services, we will reimburse the DRG Outlier Rate percentage as specified in the reimbursement section of the Agreement.

For those Facilities reimbursed on a methodology other than DRG, for Inpatient Services and Outpatient Services rendered on or after the Agreement effective date, the applicable Anthem Rate is pursuant to the reimbursement section of the Agreement. The Outlier Rate will not apply to services reimbursed in accordance with a methodology other than DRG, unless specifically identified in the reimbursement section of the Agreement. The Outlier Rate will not apply to coronary services Network services reimbursed on a Per Case Rate basis.

Fixed Outpatient Reimbursement Methodology

Fixed Outpatient Reimbursement methodology provides Anthem with the ability to reimburse outpatient Facility Claims utilizing the CPT/HCPCS Codes currently being reported on Claims. Revenue Codes will require a companion CPT/HCPCS Code when Facility’s Agreement includes Fixed Outpatient Reimbursement.

Outlier Reimbursement

Paid in accordance with the reimbursement section of the Agreement. The Outlier Rate percentage will not apply to services reimbursed as a Per Diem Rate, Per Case Rate, or Percentage Rate, unless specifically identified in the Reimbursement section of the Agreement.

Outpatient Facility Fee Schedules

The Outpatient Facility Fee Schedule methodology provides Anthem with the ability to reimburse specified Outpatient Services based on a fee schedule utilizing the CPT/HCPCS Code.
Revenue Codes Requiring Additional Coded Service Identifiers

The following is a current listing of services and Revenue Codes that will require a CPT/HCPCS Code when the Facility’s reimbursement section of the Agreement includes one or more Outpatient Facility Fee Schedules:

<table>
<thead>
<tr>
<th>Service</th>
<th>Revenue Code(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiology</td>
<td>48X, 73X</td>
</tr>
<tr>
<td>Drugs</td>
<td>25X, 63X</td>
</tr>
<tr>
<td>Lab</td>
<td>30X, 31X, 39X</td>
</tr>
<tr>
<td>PT/OT/Speech</td>
<td>42X, 43X, 44X</td>
</tr>
<tr>
<td>Radiology</td>
<td>32X, 333, 34X, 402</td>
</tr>
</tbody>
</table>

Claims that include specified CPT/HCPCS Code(s) will be reimbursed in accordance with the Anthem Rate in the reimbursement section of the Agreement unless such Claim includes a service reimbursed under a Case Rate methodology. Outpatient Facility Fee Schedule services provided in conjunction with a service reimbursed under Case Rate methodology are considered incidental to the Case Rate service and are not separately payable.

Other Outpatient Services

Anthem will reimburse other Outpatient Services not defined by fee schedule, Per Diem, Per Case, Per Visit or Per Unit at the other Outpatient Services percentage as specified in the reimbursement section of the Agreement.

Per Diem Rate

Per Diem Rate as specified in the reimbursement section of the Anthem Agreement is an all inclusive fixed payment for each full day of covered services or one (1) outpatient encounter. A full day begins at midnight and ends twenty (24) hours later. The day of admission counts as a full day. The day of discharge, death, or transfer is not counted as a full day. If admission and discharge, death or transfer occurs on the same day, the day is counted as one (1) inpatient full day.

Outpatient surgery reimbursed at a Per Diem Rate will apply multiple surgery logic.

Per Unit Rate

The flat rate payment made to a Participating Provider for all Covered Services rendered to a Covered Person for each unit of service performed within an Outpatient Service Category as indicated in the reimbursement section of the Agreement.

Per Visit Rate

Services reimbursed at a Per Visit Rate include but are not limited to physical therapy, occupational therapy, speech therapy, and respiratory therapy. A Per Visit Rate means a single date of service. Per Visit Rates include, but are not limited to: facility use, therapist/professional services, laboratory, radiology, supplies, equipment, pharmaceuticals, and other services incidental to the visit.

Semi-Private Room Rate

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

Special Procedure Room Charge

Special procedure room charges are included in the reimbursement for the procedure.
Stand-by Charges

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

Stat Charges

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

Submission of Claim/Encounter Data

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

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

Telemetry

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

Test or Procedures Prior to Admission(s)

Facility agrees to accept, consistent with Facility policies, the results of qualified and timely laboratory and radiological tests or other procedures which may have been performed on a Covered Individual prior to Facility rendering services to Covered Individuals. Facility will not require that duplicate tests or procedures be performed or charged, unless such tests or procedures are ordered by a provider.

Diagnostic services are defined by the following Revenue and/or CPT-4 Codes:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
- 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic
- 35X – CT scan
- 40X – Other imaging services
- 46X – Pulmonary function
- 48X – Cardiology with CPT codes, 93015, 93307, 93308, 93320, 93501, 93503, 93505, 93510, 93526, 93541, 93542, 93544-93552, 93561 or 93562
- 53X – Osteopathic services
- 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology or other services
- 73X – EKG/ECG
- 74X – EEG
- 92X – Other diagnostic services

Non-diagnostic services are related to the admission or outpatient procedure if they are furnished in connection with the principal diagnosis that necessitates the outpatient procedure or the Covered Individual's admission as an inpatient.
### Time Calculation

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

### Undocumented or Unsupported Charges

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

### Video Equipment used in Operating Room

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

### Additional Reimbursement Policies and Procedures

If you are a registered MyAnthem user, sign onto www.anthem.com, select provider, select state, press enter. Select the MyAnthem and login. Select the Administrative Support tab, and select the appropriate link to view Professional or Facility Reimbursement Procedures.

If you do not have a MyAnthem user ID and Password, sign onto www.anthem.com, select provider, select your state from the dropdown box, press the enter key. In the left corner of the Provider Home Page is an option to register. Complete the registration form and your ID and Password will be mailed to you within two weeks. If you are unable to complete the registration online because the provider’s tax ID is already registered, you will need to send your request to central.eprovider.repi@anthem.com.

### Medical Policies

Anthem medical policies are available at www.Anthem.com.

### Utilization Management

Overall, the provider agrees to the terms of the Agreement and the Covered Individual's Health Benefit Plan. The provider agrees to cooperate with Anthem in the development and implementation of action plans arising under these programs. The provider agrees to adhere to the following provisions and provide the information as outlined below, including, but not limited to:

#### Telephonic Pre-service Review & Concurrent Review
A. Network/Participating Provider shall ensure that non-emergency admissions and certain outpatient procedures as specified by Plan are preauthorized. Network/Participating Provider shall provide the necessary demographic information and admitting diagnosis to Anthem UM within twenty-four (24) hours or next business day of Covered Individual admission for scheduled procedures. Network/Participating Provider shall ensure that admissions that result from Emergency Services are authorized within twenty-four (24) hours of the first business day following admission.

B. Network/Participating Provider shall verify that the Covered Individual’s primary care physician has obtained a referral as required by certain Health Benefit Plans.

C. Network/Participating Provider shall comply with all requests for medical information for concurrent review required to complete Plan’s review and discharge planning coordination. In order to facilitate the review process, Network/Participating Provider shall make best efforts to supply requested information within twenty-four (24) hours of request.

D. Facility shall comply with all requests for submission of total charges for DRG Facilities. Upon Anthem’s request, Network/Participating Provider agrees to provide to Anthem the total current Facility Charges for a Covered Individual. This information will be provided by Network/Participating Provider to Anthem at no charge to Anthem.

E. Anthem specific pre-authorization requirements may be confirmed on the Anthem web site.

Medical Policies and Clinical UM Guidelines Link

Please refer to the Links section of this manual for additional information about Medical Policy and Clinical UM Guidelines.

On-Site Concurrent Review

The Facility’s UM program staff is responsible for monitoring the Covered Individual’s stay and treatment, helping to ensure the efficient use of services and resources, and evaluating available alternative outpatient treatment options. Facility agrees to cooperate with Anthem and provide Anthem with access to Covered Individuals medical records as well as access to Covered Individuals in performing on-site concurrent review and discharge planning related to, but not limited to the following:

- Emergency and maternity admissions
- Ambulatory surgery
- Case management
- Preadmission testing (“PAT”)
- Inpatient Services, including NICU
- Focused procedure review

Observation Bed Policy

Observation services are those services furnished by Facility on Facility’s premises, including the use of a bed and periodic monitoring by Facility’s nursing or other staff, which are reasonable and necessary to evaluate an outpatient’s condition or determine the need for a possible admission to Facility as an inpatient. Observation services require the written order of a physician and the reason for observation must be stated in the orders for Observation services. Upon Plan’s request, Facility agrees to provide this documentation to the Plan for review.

Retrospective Utilization Management

Retrospective UM is designed to retrospectively review Claims for services in accordance with the Covered Individual’s Health Benefit Plan. Medical records and pertinent information regarding the Covered Individual's care are reviewed by nurses (with input by physician consultants when necessary) against available benefits to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.
Failure to Comply With Utilization Management Program

Network/Participating Provider acknowledges that Plan may apply monetary penalties as a result of Network/Participating Provider's failure to provide notice of admission as required under this Agreement, or for Network/Participating Provider's failure to fully comply with and participate in any cost management procedures and/or UM programs.

Care Management

Care management is a voluntary individual benefit management program designed to encourage the use of cost effective alternatives to inpatient treatment, such as home health or skilled nursing facility care. The nurse coordinator in Plan’s care management program works with the attending physician, the Covered Individual and/or the family, and appropriate Facility personnel to both identify candidates for case management and to coordinate benefits for alternative treatment settings. The program requires the consent and cooperation of the Covered Individual, as well as collaboration with the treating physicians.

Utilization Statistics Information

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. This may include:
- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and/or identification number
- Value of test requested or any other pertinent information Anthem deems necessary.

This information will be provided by Network/Participating Provider to Anthem at no charge to Anthem.

Electronic Data Exchange

Facility will make best effort to support Anthem with electronic data exchange with information such as but not limited to daily census and confirmed discharge dates.

Rescissions

Utilization review determinations will not be reversed unless:

1. New information is received that is relevant to an adverse determination which was not available at the time of the determination, or
2. The original information provided to support a favorable determination was incorrect, fraudulent, or misleading.

For reductions or terminations in a course of treatment that has received a favorable determination, Anthem UM Services, Inc. (“AUMSI”) will use its best efforts to issue the reduction or termination early enough to allow the Covered Individual to request a review and receive a review decision before the reduction or termination occurs for concurrent reviews.

Quality of Care Incident

Network/Participating Provider will notify Anthem in the event there is a quality of care incident that involves a Covered Individual.

Audits

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

 Credentialing Scope

Anthem credentials the following health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing services covered under the Health Benefits Plan and doctors of dentistry providing Health Services covered under the Health Benefits Plan including oral maxillofacial surgeons.

Anthem also credentials behavioral health practitioners, including psychiatrists and physicians who are certified or trained in addiction psychiatry, child and adolescent psychiatry, and geriatric psychiatry; doctoral and clinical psychologists who are state licensed; master’s level clinical social workers who are state licensed; master’s level clinical nurse specialists or psychiatric nurse practitioners who are nationally and state certified and state licensed; and other behavioral health care specialists who are licensed, certified, or registered by the state to practice independently. In addition, other individual health care practitioners listed in Anthem’s Network directory will be credentialed.

Anthem credentials the following Health Delivery Organizations (“HDOs”): hospitals; home health agencies; skilled nursing facilities; (nursing homes); free-standing surgical centers; lithotripsy centers treating kidney stones and free-standing cardiac catheterization labs if applicable to certain regions; as well as behavioral health facilities providing mental health and/or substance abuse treatment in an inpatient, residential or ambulatory setting.

Credentials Committee

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

The CC will meet at least once every forty-five (45) days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will chair the CC and serve as a voting member (the Chair of the CC). The CC will include at least two participating practitioners, including one who practices in the specialty type that most frequently provides services to Anthem Covered Individuals and who falls within the scope of the credentialing program, having no other role in Anthem Network management. The Chair of the CC may appoint additional Network practitioners of such specialty type, as deemed appropriate for the efficient functioning of the CC.

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

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

Practitioners are notified that they have the right to review information submitted to support their credentialing applications. In the event that credentialing information cannot be verified, or if there is a discrepancy in the credentialing information obtained, the Credentialing staff will contact the practitioner within thirty (30) calendar days of the identification of the issue. This communication will specifically notify the practitioner of his or her right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the specific process for submission of this additional information, including where it should be sent. Depending on the nature of the issue in question, this communication may occur verbally or in writing. If the communication is verbal, written confirmation will be sent at a later date. All communication on the issue(s) in question, including copies of the correspondence or a detailed record of phone calls, will be clearly documented.
in the practitioner’s credentials file. The practitioner will be given no less than fourteen (14) calendar days in which to provide additional information.

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

Nondiscrimination Policy

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

Initial Credentialing

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

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

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

A. Practitioners

<table>
<thead>
<tr>
<th>Verification Element</th>
</tr>
</thead>
<tbody>
<tr>
<td>License to practice in the state(s) in which the practitioner will be treating Covered Individuals.</td>
</tr>
<tr>
<td>Hospital admitting privileges at a TJC, NIAHO or HFAP (formerly known as AOA) accredited hospital, or a Network hospital previously approved by the committee.</td>
</tr>
<tr>
<td>DEA, CDS and state controlled substance certificates</td>
</tr>
<tr>
<td>The DEA/CDS must be valid in the state(s) in which practitioner will be treating Covered Individuals.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
</tr>
</tbody>
</table>

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (“BCBSWI”), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (“Compcare”), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. © April, 2013 Blue Cross Blue Shield of Wisconsin
Verification Element
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report

B. HDOs

Verification Element
License to practice, if applicable
Malpractice insurance
Medicare certification, if applicable
Department of Health Survey Results or recognized accrediting organization certification
License sanctions or limitations, if applicable
Medicare, Medicaid or FEHBP sanctions

Recredentialing

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

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

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

Health Delivery Organizations

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

Recredentialing of HDOs occur every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Plan Programs or Networks must complete and submit the applicable recredentialing application, along with all required supporting documentation.

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

Site Visits

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin (“BCBSWI”), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation (“Compcare”), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies. Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association. © April, 2013 Blue Cross Blue Shield of Wisconsin
Anthem will establish specific criteria and threshold standards related to the sites where Network practitioners see Anthem Covered Individuals. These standards will address at a minimum the following: Physical accessibility for individuals with special needs, physical appearance, adequacy of examination room space, availability of appointments and adequacy of medical/treatment record keeping.

Upon receipt of a Covered Individual complaint(s) or complaints related to any of the four issues listed above, which when assessed against the criteria established exceed the threshold, Anthem will perform a site visit. The visit will be performed by an Anthem associate or agent, and will occur within sixty (60) days of receipt of the Covered Individual complaint or complaints that exceed threshold.

**Ongoing Sanction Monitoring**

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

1. Office of the Inspector General ("OIG")
2. Federal Medicare/Medicaid Reports
3. Office of Personnel Management ("OPM")
4. State licensing Boards/Agencies
5. Covered Individual/Customer Services Departments.
6. Clinical Quality Management Dept. (including data regarding complaints of both a clinical and nonclinical 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 Network/Participating Provider has been identified by these sources, criteria will be used to assess the appropriate response including but not limited to: review by the Chair of Anthem CC, review by Anthem Medical Director, referral to the CC, or termination. Anthem credentialing departments will report providers to the appropriate authorities as required by law.

**Appeals Process**

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

**Reporting Requirements**

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

I. Eligibility Criteria

Health care practitioners:

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

A. Possess a current, valid, unencumbered, unrestricted, and non-probationary license in the state(s) where he/she provides services to Covered Individuals;

B. Possess a current, valid, and unrestricted Drug Enforcement Agency (“DEA”) and/or Controlled Dangerous Substances (“CDS”) registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals; the DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals; and

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

For MDs, DOs, DPMs and oral & maxillofacial surgeons, the applicant must have current, in force board certification (as defined by the American Board of Medical Specialties (“ABMS”), American Osteopathic Association (“AOA”), Royal College of Physicians and Surgeons of Canada (“RCPSC”), College of Family Physicians of Canada (“CFPC”), American Board of Podiatric Surgery (“ABPS”), American Board of Podiatric Orthopedics and Primary Podiatric Medicine (“ABPOPPM”) or American Board of Oral and Maxillofacial Surgery (“ABOMS”) in the clinical discipline for which they are applying. Individuals will be granted five years after completion of their residency program to meet this requirement.

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

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

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

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations;
2. Application attestation signed date within one hundred eighty (180) days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on application;
5. Current, valid, unrestricted license to practice in each state in which the provider would provide care to Covered Individuals;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Covered Individuals. The DEA/CDS must be valid in the state(s) in which the practitioner will be treating Covered Individuals. Initial applicants who have NO DEA/CDS certificate will be viewed as not meeting criteria and the credentialing process will not proceed. However, if the applicant can provide evidence that he has applied for a DEA the credentialing process may proceed if all of the following are met:
   a. It can be verified that this application is pending
   b. The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,
   c. The applicant agrees to notify Anthem upon receipt of the required DEA
   d. Anthem will verify the appropriate DEA/CDS via standard sources
   e. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) day timeframe will result in termination from the Network.
      i. Initial applicants who possess a DEA certificate in a state other than the state in which they will be treating Covered Individuals will be notified of the need to obtain the additional DEA. If the applicant has applied for additional DEA the credentialing process may proceed if ALL the following criteria are met:
         (a) It can be verified that this application is pending and
         (b) The applicant has made an arrangement for an alternative practitioner to prescribe controlled substances until the additional DEA certificate is obtained,
         (c) The applicant agrees to notify Anthem upon receipt of the required DEA
         (d) Anthem will verify the appropriate DEA/CDS via standard sources applicant agrees that failure to provide the appropriate DEA within a ninety (90) day timeframe will result in termination from the Network.
      AND
         (e) Must not be currently debarred or excluded from participation in any of the following programs, Medicare, Medicaid or FEHBP.

10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
11. No history of or current use of illegal drugs or history of or current alcoholism;
12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. Other gaps in work history of six to twenty-four (6 to 24) months will be reviewed by the Chair of the CC and may be presented to the CC if the gap raises concerns of future substandard professional conduct and competence. In the absence of this concern the Chair of the CC may approve work history gaps of up to two (2) years.
14. No history of criminal/felony convictions or a plea of no contest;
15. A minimum of the past ten (10) years of malpractice case history is reviewed.
16. Meets Credentialing Standards for education/training for specialty(ies) in which practitioner wants to be listed in an Anthem Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for

Anthem Blue Cross and Blue Shield is the trade name of Blue Cross Blue Shield of Wisconsin ("BCBSWI"), which underwrites or administers the PPO and indemnity policies; Compcare Health Services Insurance Corporation ("Compcare"), which underwrites or administers the HMO policies; and Compcare and BCBSWI collectively, which underwrite or administer the POS policies, Independent licensees of the Blue Cross and Blue Shield Association. © ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.

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DPMs and oral & maxillofacial surgeons;
17. No involuntary terminations from an HMO or PPO;
18. No “yes” answers to attestation/disclosure questions on the application form with the exception of the following:
   a. investment or business interest in ancillary services, equipment or supplies;
   b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
   c. voluntary surrender of state license related to relocation or nonuse of said license;
   d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.
   e. non-renewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);
   f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window.
   g. actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
   h. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

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

B. Currently Participating Applicants (Recredentialing)
1. Submission of complete re-credentialing application and required attachments that must not contain intentional misrepresentations;
2. Re-credentialing application signed date within one hundred eighty (180) days of the date of submission to the CC for a vote;
3. Primary source verifications within acceptable timeframes of the date of submission to the CC for a vote, as deemed by appropriate accrediting agencies;
4. No evidence of potential material omission(s) on re-credentialing application;
5. Current, valid, unrestricted license to practice in each state in which the practitioner provides care to Covered Individuals;
6. *No current license probation;
7. *License is unencumbered;
8. No new history of licensing board reprimand since prior credentialing review;
9. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per OIG and OPM Reports or on NPDB report);
10. Current DEA, CDS Certificate and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
11. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network/Participating Provider of similar specialty at a Network hospital who provides inpatient care to Covered Individuals needing hospitalization;
12. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
13. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
14. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
15. Malpractice case history reviewed since the last CC review. If no new cases are identified since last review, malpractice history will be reviewed as meeting criteria. If new malpractice history is present, then a minimum of last five (5) years of malpractice history is evaluated and criteria consistent with initial credentialing is used.
16. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
17. No new (since previous credentialing review) “yes” answers on attestation/disclosure questions.
with exceptions of the following:

a. investment or business interest in ancillary services, equipment or supplies;

b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;

c. voluntary surrender of state license related to relocation or nonuse of said license;

d. a NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria.

e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier’s business practices (no longer offering coverage in a state or no longer in business);

f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window.

g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;

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

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

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

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

Note: the CC will individually review any Network/Participating Provider that does not meet one or more of the criteria for recredentialing.

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

Practitioners must have a minimum of two (2) years experience post-licensure in the field in which they are applying beyond the training program or practice in a group setting where there is opportunity for oversight and consultation with a behavioral health practitioner with at least two (2) years of post licensure experience.

1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:

   a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE").

   b. Program must have been accredited within three (3) years of the time the practitioner graduated.

   c. Full accreditation is required, candidacy programs will not be considered.

   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet the criteria, the doctoral program must be accredited by the APA or be regionally accredited by the Council for Higher Education ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.

2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:

   a. Master’s or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.

   b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.

   c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.

   e. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed as such, the practitioner can be reviewed. To meet
criteria this doctoral program must either be accredited by the APA or be regionally accredited by the 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/psychiatric and mental health nurse practitioner:
   a. Master’s degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the practitioner’s graduation.
   b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (“ANA”) in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.
   d. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a Network/Participating Provider as applicable by the state licensing board. For those who possess a DEA Certificate, the appropriate CDS Certificate if required. The DEA/CDS must be valid in the state(s) in which the provider will be treating Covered Individuals.

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

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

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body. HDOs are recredentialed at least every three (3) years to assess the HDO’s continued compliance with Anthem standards.

A. General Criteria for HDOs:
   1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
   2. Valid and current Medicare certification.
3. Liability insurance acceptable to Anthem.
4. Cooperate in Anthem’s UM and quality improvement programs.

B. Additional Participation Criteria for HDO by Provider Type:

1. Hospital: Must be accredited by TJC, NIAHO or HFAP (formerly referred to as AOA Hospital Accreditation Program)

2. Ambulatory Surgery Center: Must be accredited by TJC, HFAP, Accreditation Association for Podiatric Surgical (“AAPS”), Accreditation Association for Ambulatory Health Care (“AAAHC”), American Accreditation of Ambulatory Surgery Facilities (“AASA”), or Institute for Medical Quality (“IMQ”).

3. Home Health Care Agency: Must be accredited by TJC, HFAP, Community Health Accreditation Program (“CHAP”) or Accreditation Commission for Health Care (“ACHC”).

4. Skilled Nursing Facility: Must be accredited by TJC, HFAP or CARF.

5. Nursing Home: Must be accredited by TJC.

6. Free Standing Cardiac Catheterization Facilities: Must be accredited by the TJC or HFAP (may be covered under parent institution).

7. Lithotripsy Centers: Must be accredited by TJC.

8. Behavioral Health Facility:
   a. The following behavioral health facilities must be accredited by the TJC or CARF as indicated.
      i. Acute Care Hospital – Psychiatric Disorders (TJC, HFAP or NIAHO)
      ii. Residential Care – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF)
      iii. Partial Hospitalization/Day Treatment – Psychiatric Disorders (TJC, HFAP, NIAHO or CARF for programs associated with an acute care facility or residential treatment facilities.)
      iv. Intensive Structure Outpatient Program – Psychiatric Disorders (TJC, HFAP or NIAHO for programs affiliated with an acute care hospital or health care organization that provides psychiatric services to adults or adolescents or CARF if program is a residential treatment center providing psychiatric services)
      v. Acute Inpatient Hospital – Chemical Dependency/Detoxification and Rehabilitation (TJC, HFAP or NIAHO)
      vi. Acute Inpatient Hospital – Detoxification Only Facilities (TJC, HFAP, NIAHO)
      vii. Residential Care – Chemical Dependency (TJC, HFAP, NIAHO or CARF)
      viii. Partial Hospitalization/Day Treatment – Chemical Dependency (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; Civilian Health and Medical Program of the Uniformed Services (“CHAMPUS”) or CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)
      ix. Intensive Structure Outpatient Program – Chemical Dependency (TJC or NIAHO for programs affiliated with a hospital or health care organization that provides drug abuse and/or alcoholism treatment services to adults or adolescents; CARF for programs affiliated with a residential treatment center that provides drug abuse and/or alcoholism treatment services to adults or adolescents)

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Standards of Participation

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

<table>
<thead>
<tr>
<th>Provider</th>
<th>Standards of Participation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance (Air &amp; Ground)</td>
<td>Medicare Certification</td>
</tr>
<tr>
<td>Ambulatory Infusion Suites</td>
<td>TJC, CHAP or ACHC, State &amp; Pharmacy Licensure</td>
</tr>
<tr>
<td>Home Infusion Providers</td>
<td>TJC, CHAP or ACHC, State &amp; Pharmacy Licensure</td>
</tr>
<tr>
<td>Provider</td>
<td>Standards of Participation</td>
</tr>
<tr>
<td>Clinical Reference Laboratories</td>
<td>CLIA Certification, Medicare Certification</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>TJC, CHAP, ACHC, Medicare Certification</td>
</tr>
<tr>
<td>Hearing Aid Supplier</td>
<td>State Licensure</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>TJC, CHAP, ACHC, State &amp; Pharmacy Licensure</td>
</tr>
<tr>
<td>Hospice</td>
<td>Medicare Certification</td>
</tr>
<tr>
<td>Orthotics &amp; Prosthetics</td>
<td>TJC, CHAP, ABC or BOC (Ocularist: NEBU Preferred), Medicare</td>
</tr>
<tr>
<td></td>
<td>Certification</td>
</tr>
<tr>
<td>Dialysis Facilities</td>
<td>Medicare Certification</td>
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</tbody>
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*Please note: This is only a representative listing of provider types that do not require formal credentialing. If you have questions about whether you are subject to the formal credentialing process or the applicable standards of participation for your provider type, please call Network Management.

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**Quality Improvement Program**

**Quality Improvement Programs**

"Quality Improvement Program” means certain quality improvement related programs and activities which may include, without limitation, evaluation of and efforts to improve the quality and efficiency of the use of Health Services, procedures and facilities on a prospective, concurrent or retrospective basis.

Anthem conducts an ongoing review of qualifications to determine Facility participation in its Networks. Facilities participating in Anthem Networks shall implement and maintain Quality Programs in accordance with Anthem’s requirements and performance targets, including, but not limited to:

- **Governing Body or Advisory Board** – Facility shall have a board of directors or trustees or other governing entity appropriate to the type of Facility seeking participation status.
- **Upon request**, Facility shall also provide Plan or its designees with reasonable data that are commonly accepted to be indicators of Facility’s quality of care.
- **A hospital quality scorecard (“Hospital Quality Scorecard”) based on the information provided by Network Providers shall be completed by Facility at yearly intervals and provided to Anthem. Network Providers will receive a copy of their individual scorecard. Each Network Provider is required to maintain a minimum target score, as determined by Anthem, on its Hospital Quality Scorecard.**
- **In provider directories published by Anthem for use by Anthem Covered Individuals and others, Network Providers not in compliance with the quality improvement program may be designated with an asterisk (*) and an appropriate tagline.**

**Performance Data**

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

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

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

**Accreditation or Certification**

Facility shall be accredited by TJC or HFAP and/or be certified as a provider of care pursuant to Title XVIII of the Medicare Program. Additionally, Facility shall hold a current unlimited non-probationary license as an acute care facility in all jurisdictions requiring licensure of acute care facilities.

Additionally, upon request, the following information shall be required, as applicable:

- A copy of TJC or HFAP accreditation letter must be submitted for review by Anthem, along with any explanation of adverse conditional, probationary, or non-accreditation status in the last seven (7) years, if accredited. If not accredited by TJC or HFAP Anthem has the right to request further documentation and the option to conduct an on-site quality assessment of the Facility.

- Any recommendations for improvement from TJC, HFAP, CMS or state licensing agency must also be submitted to Anthem upon request.

**Compliance Documentation**

The following information shall be provided to Anthem by Facility upon initial execution of the Agreement and also upon written request by Anthem, not more than once annually.

1. A copy of Facility’s current unlimited non-probationary license as a general acute care facility, along with any explanations of disciplinary action in the last seven (7) years.
2. A copy of Facility’s current unrestricted Federal Drug Enforcement Agency Registration Certificate along with any explanations of disciplinary action in the last seven (7) years.
3. A copy of Facility’s current Medicare and Medicaid Certification along with any explanation of disciplinary actions or financial penalties in the last seven (7) years.
4. A copy of the most recent audited Facility financial statements for the past two (2) years.
5. A copy of Facility’s current medical malpractice insurance face sheet.

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**Centers of Medical Excellence (CME) Transplant Network**

**Anthem Centers of Medical Excellence (“CME”) Transplant Network**

The CME designation is awarded by WellPoint to those programs meeting the participation requirements for WellPoint’s transplant network and all other future specialty networks developed by WellPoint. Each Center is selected through a rigorous evaluation of clinical data that provides insight into the 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.

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

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

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

**Blue Distinction® Centers for Transplants**

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

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

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

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

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

**Covered Individual Grievance and Appeal Process**

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

Procedures for registering complaints and appeals are outlined in the Covered Individual’s certificate of coverage. Refer to the Anthem Medicare Advantage HMO and PPO provider manual for a description of Medicare Advantage procedures for Covered Individual grievances and appeals.

**Complaints**

Complaints include any expression of dissatisfaction regarding Anthem’s services, products, Network/Participating Providers and employees.
• Anthem’s Covered Individual services department logs oral and written complaints into a tracking system, may research the issue, if appropriate, and responds to the Covered Individual.

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

**Appeals**

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

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

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

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

• Covered Individuals or their representative may request either a standard or panel appeal for initial.

• Most Covered Individuals who have the right to panel review may also be allowed a personal appearance before the appeals panel. Please refer the Covered Individual to their Health Benefit Plan for details. (This does not apply to Medicare Advantage Covered Individuals.)

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

**Quality of Care Issues**

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

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

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**Provider Complaint and Appeals Process**

Anthem encourages Network/Participating Providers to seek resolution of issues by using the provider complaint and appeal process outlined in detail in this provider manual. The provider complaint and appeal process is designed to provide appropriate and timely review when Network/Participating Providers disagree with a decision made by Anthem. The procedures also meet requirements of state laws and accreditation agencies.

The building blocks of Anthem’s provider complaint and appeal process are the ‘complaint’ and the ‘appeal’. A complaint is any expression of dissatisfaction to Anthem by a Network/Participating Provider. In most instances, initial requests for Anthem to change a previous decision other than an adverse UM decision will be handled exclusively as complaints. For some issues, the complaint is the only level of review available. An appeal is a formal request for Anthem to change a decision upheld by Anthem through the complaint process or, in the case of an adverse UM decision, a request by a provider for Anthem to change that decision.

**How Administrative Issues are Handled**
Operational complaints and appeals can be submitted to Anthem’s provider inquiry department. Examples of administrative issues include Claim processing, benefit interpretation and reimbursement. For most issues involving reimbursement, the complaint is the only level of review. For other operational issues, a standard appeal (single level of review) may be offered if the Network/Participating Provider is not satisfied with the response to the complaint.

How Clinical Issues are Handled

Clinical appeals are requests to change decisions based on whether services or supplies are Medically Necessary or experimental/investigative. UM program clinical appeals involve certification decisions, Claims or predetermination decisions evaluated on these bases. For clinical issues, there are two (2) types of review; standard and expedited. Anthem offers an expedited appeal for decisions involving urgently needed care. Both standard and expedited appeals are reviewed by a person who did not make the initial decision.

When a Network/Participating Provider expresses dissatisfaction about an adverse UM program decision involving a clinical issue, the case is automatically handled as an appeal or a reconsideration rather than as a complaint. A reconsideration is when Anthem, upon request by a treating physician, reevaluates the initial determination. Reconsiderations are handled outside of the appeals process and in accordance with Anthem UM policies. A standard appeal is available following the reconsideration, or initially if a reconsideration is not requested in a timely manner. An expedited appeal is available for urgently needed care.

A standard appeal is available following an expedited appeal.
Timeframes for Submitting Complaints and Appeals

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

All standard clinical appeals (pre-service and post-service) will be resolved within a reasonable period of time appropriate to the medical circumstances, but not later than thirty (30) calendar days from the receipt of the grievance request by Anthem.

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

How Special Complaints and Appeals are Handled

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

Covered Individual Complaints and Appeals

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

Network Participation Appeals

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

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

For More Information

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

Product Summary

BlueCard Web Site

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

Federal Employee Program (FEP) Web Site

Please refer to the Federal Employee Program (FEP) Web Site at www.fepblue.org for additional information.
Facility Audit

Enterprise Audit Policy

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

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

Definition:

The following definitions shall apply to this Audit section only:

- Agreement means the written contract between Anthem and Network/Participating Provider that describes the duties and obligations of Anthem and the Network/Participating Provider, and which contains the terms and conditions upon which Anthem will reimburse Network/Participating Provider for health care services rendered by Network/Participating Provider to Anthem Covered Individual(s).

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

- Appeal Response means Anthem’s written response to the Appeal after reviewing all Supporting Documentation provided by Network/Participating Provider.

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

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

- Network/Participating Provider means an entity with which Anthem has a written Agreement.
• Provider Manual means the proprietary Anthem document available to Network/Participating Provider, which outlines certain Anthem Policies.

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

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

Procedure:

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

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

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

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

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

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

7. **Completion of Audit.** Upon completion of the Audit, Plan will generate and give to Network/Participating Provider a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be provided within five (45) calendar days of the request.
be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Plan will discuss with Network/Participating Provider, its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Network/Participating Provider agrees with the Audit findings, and has no further information to provide to Plan, then Network/Participating Provider may sign the final Audit Report acknowledging agreement with the findings. At that point, Network/Participating Provider has thirty (30) calendar days to reimburse Plan the amount indicated in the final Audit Report. Should the Network/Participating Provider disagree with the final Audit Report generated during the exit interview, then Network/Participating Provider may either supply the requested documentation, or Appeal the Audit findings.

8. Network/Participating Provider Appeals. See Audit Appeal Policy.

9. No Appeal. If the Network/Participating 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 Plan will process adjustments to recover amount identified in the final Audit Report.

Documents Reviewed During an Audit:

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

A. Confirm that services were delivered by the Network/Participating Provider in compliance with the physician’s plan of treatment.

Auditors will verify that Network/Participating Provider’s plan of treatment reflected the services delivered by the Network/Participating 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 Network/Participating Provider may present other documents substantiating the treatment or service, such as established institutional policies, professional licensure standards that reference standards of care, or business practices justifying the service or supply. The Network/Participating 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 Plan’s Policies as well as general industry standard guidelines and regulations.

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

1. Unless otherwise expressly set forth in an Agreement, Network/Participating Provider shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem within thirty (30) calendar days of the date of the Audit Report. The request for Appeal must specifically detail the findings from the Audit Report that Network/Participating Provider disputes, as well as the basis for the Network/Participating Provider’s belief that such finding(s) are not accurate. All findings disputed by the Network/Participating Provider in the Appeal must be accompanied by relevant Supporting Documentation. If no Supporting Documentation is submitted to substantiate the basis for the Network/Participating Provider’s belief that a particular finding is not accurate the Network/Participating Provider will be notified of the denial and have thirty (30) calendar days to send a remittance check to Anthem, if applicable in the state. If no remittance check is received within the thirty (30) day timeframe or if Network/Participating Provider does not respond to an Audit Report within thirty (30) calendar days of the date of such Report, Anthem will begin Recoupment proceedings within ten (10) days, unless expressly prohibited by an Agreement.

2. A Network/Participating Provider’s written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem on a case-by-case basis. If the Network/Participating 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 or within thirty (30) calendar days of the receipt of Anthem’s appeal response and submitted to the Appeals coordinator identified within the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem’s sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. A written notification of approval or denial of an Appeal extension will be mailed to the Network/Participating Provider within seven (7) calendar days. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Network/Participating 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 shall issue an Appeal Response to the Network/Participating Provider. Anthem’s response shall address each matter contained in the Network/Participating Provider’s Appeal. If appropriate, Anthem’s Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem’s response shall be sent via certified mail to the Network/Participating Provider within sixty (60) calendar days of the date Anthem received the Network/Participating Provider’s Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.

4. The Network/Participating Provider shall have thirty (30) calendar days from the date of Anthem’s response to send a response or, if appropriate in the state, a remittance check to Anthem. If no Network/Participating Provider response or remittance check (if applicable) is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem’s response, and a confirming Recoupment notification will be sent to the Network/Participating Provider.

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

6. If applicable in the state, the Network/Participating Provider shall have thirty (30) calendar days from the date of Anthem’s final Appeal Response to send a remittance check to Anthem. If no remittance check is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem’s final response.

Exceptions: This Audit Appeal Policy does not apply to Medicare Advantage, Medicare Private Fee for Service or New York physician Claims.
Appeal Response, and a confirming Recoupment notification will be sent to the Network/Participating Provider.

7. If Network/Participating Provider still disagrees with Anthem’s position after receipt of the final Appeal Response, Network/Participating Provider may invoke the dispute resolution mechanisms under the Agreement.