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Purpose and Introduction

Anthem Blue Cross and Blue Shield and our subsidiary company, HMO Nevada (hereinafter collectively referred to as “Anthem”), are independent licensees of the Blue Cross and Blue Shield Association. We each maintain a network of independent physicians, multi-specialty group practices, ancillary providers and health care facilities contracted to provide health care services to our Covered Individuals.

Provider: The use of Provider within this manual refers to entities contracted with Anthem/Plan that bill on a CMS 1500. They may also be referred to professional providers in some instances.

Facility: The use of Facility within this manual refers to entities contracted with Anthem/Plan that bill on a UB 04, such as Acute General Hospitals and Ambulatory Surgery Centers.

In the appropriate context, “provider” or “Provider” may refer to both Provider and Facility type providers.

We know how complicated the health insurance and managed care industry has become, and we understand how that complexity can affect your office or facility. The Manual contains information about claims submission, reimbursement processes and methodology, authorizations, who to contact at Anthem and other key information to make your relationship with us run as smoothly as possible.
Legal and Administrative Requirements Overview

Insurance Requirements

A. Providers and Facilities shall, during the term of their Agreements with Anthem, 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 the Agreement. If this insurance policy is written on a claims-made basis, and said policy terminates and is not replaced with a policy containing a prior acts endorsement, Providers and Facilities agree 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 Provider or Facility may have less insurance coverage if the patient compensation fund,
when considered with Provider’s or Facility’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 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 Provider or Facility 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. Providers and Facilities shall notify Anthem of a reduction in, cancellation of, or lapse in coverage within ten (10) days of such a change. A certificate of insurance shall be provided to Anthem upon request.

Dispute Resolution and Arbitration

The substantive rights and obligations of Anthem Providers and Facilities 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 Provider or Facility, 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 statute 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.

Open Practice

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

Directory of Services/Provider Resource Information

Provider Contact Information

We provide two main documents for contact information for our providers:

1. **Alpha Prefix Reference List** – one page list provides customer service phone numbers, address information for claims, adjustments, appeals, and correspondence, as well as Authorization phone number information.
   - This list is split out by member type, as identified by the member’s three (3) character alpha prefix in front of their ID number.
   - This will help ensure you can contact the appropriate customer service, or authorization unit the first time to avoid unnecessary transfers.

2. **Escalation Contact List** – This document outlines our escalation process and includes phone numbers and email addresses for our team leads and managers in many of our provider servicing areas. It includes contact information for the following areas:
   - Local Provider Customer Service
   - Federal Employee Program Provider Customer Service
   - BlueCard Provider Customer Service
   - Pre-certification/Authorizations
   - ProviderAccess Support Team
   - Electronic Data Interchange (“EDI”) Solutions Team
   - Nevada Medical Directors Back line
   - Provider Engagement and Contracting:
     - Provider Relations
     - Provider Contracting
     - Provider Education/Communication

Our contact information is also posted online. Go to anthem.com, select the **Provider** link in upper left corner. Select **Nevada** from drop down list and **enter**. From the **Provider Home** tab, select the link titled **Contact Us Escalation Contact List & Alpha Prefix Reference List**.
Provider Communications

Our provider communications are primarily sent via email or fax. All of our communications are also posted online at anthem.com.

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Provider Communications.

- To register to receive our communications, please fill out our Anthem Network eUpdate form – It’s fast, efficient and NO COST! To register, simply:
  - Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled “Anthem Network eUpdate (registration form).”

Complete and submit the simple registration form for immediate registration.

Provider Newsletter

Provider Newsletter, Network Update – We distribute a monthly newsletter to our providers that goes out on the first Friday of every month.

- Our Provider Newsletters are also posted online. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Network Update (Provider Newsletter).

- To register to receive our newsletters, please fill out our Anthem Network eUpdate form – It’s fast, efficient and NO COST! To register, simply:
  - Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled “Anthem Network eUpdate (registration form).”
  - Complete and submit the simple registration form for immediate registration.

Provider Seminars

Provider seminars are conducted twice a year – spring and fall, and the information is also posted online.

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Provider Seminars.

Provider In-Service

Provider In-Services, one-on-one meetings – Providers and Facilities can request an in-service or one-on-one meeting with his/her Provider Contract and/or Provider
Relations representative. If you would like to request a visit, or training on a specific topic, please feel free to contact your Provider Contracting and/or Provider Relations representative to schedule a meeting. (Please see the Escalation Contact List for direct contact information).

Provider Toolkit

We have created a toolkit online for providers to access with helpful references, quick links to provider information, as well as contact information, and educations tools including:

- Anthem 101 for Nevada Providers
- Membership Health Plan ID Card samples
- Provider EOB/RA Frequently Asked Questions
- View Policies
- Quick Links to:
  - Provider Manual
  - Provider newsletter, Network Update
  - Provider Communications
  - ProviderAccess Demo
- Contact Information:
  - Alpha Prefix Reference List
  - Escalation Contact List

Our Provider Toolkit information is posted online. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Provider Toolkit.

Online Provider Directory

For a complete listing of Providers and Facilities, please check our online directory. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

- Note: laboratories are listed under Provider Type of “Hospitals, Facilities, Services, and Equipment” and pathologists are listed under Provider Type of “Other Health Professionals”.

Primary Care Physician Change Request

HMO Nevada Covered Individuals must select a primary care physician (“PCP”) of their choice from the HMO Nevada network. Customer service grants and processes PCP change requests.

Procedure

- A Covered Individual can request to change PCPs by calling HMO Nevada’s customer service department.
• If the Covered Individual indicates a potential quality issue or grievance and complaint at the time of the change request, customer service will ask the Covered Individual to submit additional information in writing about the potential issue. If we receive written notice of a potential quality issue or grievance and complaint, we’ll send it to the grievance and complaint department for research. An associate from that department will communicate HMO Nevada’s resolution/action related to the potential issue to the Covered Individual and to the provider. The grievance and complaint department maintains a copy of this correspondence in its confidential files.

• This process may take at least thirty (30) calendar days for research and processing of a potential quality issue or grievance and complaint that requires investigation.

• Customer service will process the Covered Individual’s PCP change request and, if approved, the effective date of the change.

**Member Notification Regarding Provider Termination**

When a Provider or Facility’s contract is terminated, Anthem will notify members as required by state law and related regulations, as amended from time to time.

**Provider File and Online Directory Management**

Our online provider directory lists physicians, hospitals and other health care professionals in our networks (see Provider Online Directory section). The provider directory provides the most up-to-date information available about Providers and Facilities.

We invite you to check your own listing in our online provider directory to ensure the information we provide to our members about you is accurate. If any of your information is incorrect, please complete the [Provider Change Form](#). You must submit any provider file updates, i.e., address change, tax ID change, etc., in writing and with a new W-9 form. Mail or fax the completed form to the following address or fax number:

Anthem Blue Cross and Blue Shield / HMO Nevada  
Provider Engagement and Contracting  
9133 West Russell Road  
Las Vegas, NV 89148  
Fax: 866-767-9851

Please include your **full name, tax ID number and ZIP code** so we can easily identify you and promptly update your file.

**Provider Change Form**

This form is available in electronic format for typing your information. Go to [anthem.com](http://anthem.com), select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Answers@Anthem tab, select the link titled 'Download Commonly Requested Forms', then "Provider Change Form".
Provider Portal Connectivity Options

Provider portal options for Providers and Facilities

ProviderAccess – Anthem’s secure provider portal:

- Available for Anthem membership only
- Includes Local Plan, BlueCard, and Federal Employee Program (FEP) members

Availity – multi-payer portal:

- Available for Anthem membership starting in April 2012
  - Includes Local Plan, BlueCard, and Federal Employee Program (FEP) members
- Access other payers in Nevada along with Anthem information on one portal

ProviderAccess®

What is ProviderAccess®?

Anthem’s ProviderAccess functions provide helpful online tools that let providers get information in a secure environment without having to call our customer service units. Our goal in offering these online options is to help make it easy for you to do business with us.

In 2012-2013, much of the functionality on ProviderAccess will move to being accessed exclusively on Availity. ProviderAccess users can currently view eligibility and benefits, claim status, and online remittances, as well as inquire on the status of previously submitted medical referral or pre-authorization, via the Medical Referral & Pre-Authorization Inquiry tool. IMPORTANT: As a result of Availity’s ease of use and detail provided, we are targeting late 2013 to begin to shut down functionality on our legacy Provider Portal, ProviderAccess. Web portal access to certain functionalities, including Eligibility and Benefits Inquiry, Claim Status Inquiry and Secure Messaging will be available exclusively through Availity, our multi-payer portal solution.

Our ProviderAccess online services are available at anthem.com and include the following real-time information:

How to Get Started with ProviderAccess

2. Click the Providers link in the upper left corner.
3. Select Nevada from the state drop-down box, and Enter.
4. Select Medical.
5. Click on the “Register Now” link on the left in the blue box on the left side of page titled “ProviderAccess Login”.
6. Complete the registration online. You will receive email confirmation usually within 1 business week.

For questions or issues during the registration process, please email provideraccesswest@anthem.com.

Overview Tab

- Quick links to helpful resources/documents
  - Provider News
  - Provider Manual
  - Download Commonly Requested forms
  - View Policies (Reimbursement Policies, Medical Policies, Clinical UM Guidelines)

Eligibility and Benefits Tab (for Local, FEP and BlueCard members)

- Co-pay, deductible and co-insurance amounts
- Primary Care Physician ("PCP"), if applicable
- Type of Health Benefit Plan
- Routine benefit descriptions
- Accumulations for deductibles and out-of-pocket maximums

Claims Tab (for Local, FEP and BlueCard members)

- Claims Status
- Online Provider Remittances –
  - View and save your remittances online anytime - 24/7.
- Clear Claim Connection
  - A tool for evaluating clinical coding information supplied by McKesson, Inc. It allows providers to view clinically based information along with documented source information for approximately 2 million edits also incorporating editing for some of our reimbursement policies.
- Claim reports
  - Run your own claims reports for all claims paid, processed or denied for Local and BlueCard claims
- Contracted Pricing
  - Professional contracted pricing tool, allows providers to enter CPT codes and see contracted pricing by line of business. (Does not include site of service, only non-facility pricing).
Referrals & Pre-authorizations Tab

- Authorizations for radiology services (see the Referrals and Pre-certifications section for specifics)
  - Ordering providers can obtain authorizations online
  - Servicing providers can inquire to see if an authorization is in place
- Medical Referrals & Pre-authorizations Inquiry
  - View inquiry status for previously submitted medical authorization requests on inpatient admissions, outpatient services, and office consultations.

Advantages of ProviderAccess

- It’s available to you at no cost.
- Your office doesn’t need any special programming or software. All you need is internet access.
- Improve self-service capabilities.
- It helps you reconcile your accounts receivable with claim reports.
- Claim status inquiries are available for claims whether or not they are submitted on paper or electronically.
- There are no requirements to be contracted with Anthem to use this tool.

ProviderAccess Support

A password is required to access the screens on our ProviderAccess site. Passwords can be retrieved and reset online without making a phone call to the ProviderAccess Support Team.

We have dedicated associates in our ProviderAccess Support Team who will educate you and your staff about how to access Anthem’s ProviderAccess site, verify eligibility, check claims status, and print reports on all paper and electronic claims.

For ProviderAccess questions or issues, please call the ProviderAccess Support Team at 866-302-1384.

Availity®

Availity services offered to Anthem providers

Anthem is pleased to announce the expansion of our provider portal services through Availity®, a multi-payer web portal. Using a single sign-on, you are now able to access multiple payers to check eligibility, claims and many other services through Availity.

Anthem services available at www.availity.com:
• **Eligibility and Benefits**: Real-time requests and responses are available through the Availity multi-payer portal, including local, BlueCard and FEP Covered Individuals.

• **Claim Status Inquiry**: Real-time requests and responses including local, BlueCard and FEP Covered Individuals.

• **Secure Message Inquiry**: Send a question to clarify the status of a claim or to get additional information on claims, including local, BlueCard and FEP Covered Individuals.

• **Clinical Messaging**: Clinical alerts on Covered Individual’s care gaps and medication compliance indicators.

• **CareProfile**: Real-time, consolidated view of a Covered Individual’s medical history based on claims information across multiple providers.

• **Imaging and Specialty Rx Pre-certification Requests**: Access to AIM Specialty Health for imaging, specialty Rx, sleep studies and radiation therapy pre-certifications.

• **Certificate of Coverage**: View a local plan member’s certificate of coverage online.

• **Online Remits** – under Claims Management/Remittance Review Link out to ProviderAccess login page to access online remits. (You will need to Login to ProviderAccess, but you will now save you the step of logging into ProviderAccess through a separate window, and instead have a new link to route you directly to the ProviderAccess login page. This is an interim solution to bringing the Remittance Advices directly to Availity, but hopefully a more convenient step in the interim).

**Note**: The user must have an active UserID on ProviderAccess to access Secure Messaging functionality, AIM Specialty Health, and online remittances.

Availity is a FREE, secure multi-health plan portal

Availity's secure multi-health plan portal – available at no charge to physicians, hospitals and other health care professionals – 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.

Advantages of using Availity

Benefits include:

• **No charge** – Health plan transactions are available at no charge to providers, while at the same time saving time and money.

• **Accessibility** – Availity functions are available 24 hours a day from any computer with Internet access.

• **Standard responses** – Availity returns responses from multiple payers in the same format and screen layout, providing users with a consistent look and feel.
• Commercial and Government Payers – Access to data from Anthem, Medicare, Medicaid and other commercial carriers. (See www.availity.com for a full list of payers)

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

Availity Registration Information

To register for access to Availity, go to www.availity.com/providers/registration-details/.

Once you log into the secure portal, you'll have access to free live training to jumpstart your learning, frequently asked questions, comprehensive help topics and other resources to help ensure you get the most out of your Availity experience. Client service representatives are also available Monday through Friday to answer your questions at 800-AVAILITY (800-282-4548).

Note: Availity services and coverage expand all the time. Please check frequently for new offerings.

Eligibility

Member Health Plan ID Cards

Health Benefit Plans, amendments and coverage notices are available to all Anthem group and non-group subscribers and to all HMO Nevada group subscribers at anthem.com. Subscribers may also request a printed copy of their Health Benefit Plan by mailing the postage-paid postcard included with their health plan ID card(s), or by calling the customer service number on their ID card. The Health Benefit Plan, amendments and coverage notices explain the type of coverage and benefits available to the member, as well as limitations and exclusions.

Anthem mails health plan ID cards to all Anthem and HMO Nevada groups (i.e., to the employer or to the group subscribers) and to all non-group subscribers. Some local Nevada member health plan ID cards list an issue date and an effective date. The card issue date is the date the card was printed. The effective date is the date the benefits under the member’s Health Benefit Plan were available to the member. With each visit, please ask members for the most current copy of their health plan ID card.

Samples of our Member Health Plan ID Cards are available in our Provider Toolkit online at anthem.com. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Provider Toolkit, and “Membership Health Plan ID Card Samples”.
Verifying Member Coverage

Member health plan ID cards include information about verifying member eligibility. Possession of a health plan ID card does not guarantee that the person is an eligible member. If a member does not have a health plan ID card, please contact Anthem customer service or BlueCard eligibility at the phone numbers in the Alpha Prefix Reference List.

Claims Submission/Claim Action Request Procedures

Claims Requirements

A claim is the uniform bill form or electronic submission form in the format used by Anthem and submitted for payment by a provider for Covered Services rendered to an Anthem member. Anthem only accepts one member and one provider per claim.

We encourage you to submit claims electronically. Electronic claims submission is fast, accurate and reliable. Electronic claims may be submitted twenty four (24) hours a day, seven (7) days a week. If complete information is provided, they will typically be processed seven to 10 days faster than paper claims. Please see the Electronic Claims Submission subsection in this section of the Manual for more information. Also visit our web site at anthem.com/edi then select your state. Here you will find information on EDI transactions.

If submitting claims electronically is not a viable alternative, claims must be submitted on a CMS-1500 claim form for professional and other non-facility services and on an UB-04 CMS-1450 claim form for services provided in a facility. To be considered a clean claim, the following information is MANDATORY, as defined by applicable law, for each claim:

A. The following fields of the CMS-1500 claim form must be completed before a claim can be considered a “clean claim:"

1. Field 1: Type of insurance coverage
2. Field 1a: Insured ID number
3. Field 2: Patient’s name
4. Field 3: Patient’s birth date and sex
5. Field 4: Insured’s name
6. Field 5: Patient’s address
7. Field 6: Patient’s relationship to insured
8. Field 7: Insured’s address (if same as patient address; can indicate “same”)
9. Field 8: Patient’s status (required only if patient is a dependent)
10. Field 9 (a-d): Other insurance information (only if 11d is answered in “yes”)
11. Field 10 (a-c): Relation of condition to: employment, auto accident or other accident;
12. Field 11: Insured’s policy, group or FECA number
13. Field 11c: Insurance plan or program name
14. Field 11d: Other insurance indicator
15. Field 12: Information release (“signature on file” is acceptable)
16. Field 13: Assignment of benefits (“signature on file” is acceptable)
17. Field 14: Date of onset of illness or condition
18. Field 17: Name of referring physician (if applicable)
19. Field 21: Diagnosis code
20. Field 23: Prior authorization number (if any)
21. Field 24: A, B, D, E, F, G Details about services provided
   (C, H Medicaid only)
22. Field 24 I, J: Non-NPI provider information
23. Field 25: Federal tax ID number
24. Field 28: Total charge
25. Field 31: Signature of provider including degrees or credentials (provider name
   sufficient)
26. Field 32: Address of facility where services were rendered
27. Field 32a: National Provider Identifier (NPI);
28. Field 32b: Non-NPI (QUAL ID), as applicable
29. Field 33: Provider’s billing information and phone number
30. Field 33a: National Provider Identifier (NPI); and
31. Field 33b: Non-NPI (QUAL ID), as applicable

B. The following fields of the UB-04 CMS-1450 claim form must be completed for a
claim to be considered a “clean claim:"

1. Field 1: Servicing provider’s name, address, and telephone number
2. Field 3: Patient’s control or medical record number
3. Field 4: Type of bill code
4. Field 5: Provider’s federal tax ID number
5. Field 6: Statement Covers Period From/Through
6. Field 8: Patient’s name
7. Field 9: Patient’s address
8. Field 10: Patient’s birth date
9. Field 11: Patient’s sex
10. Field 12: Date of admission
11. Field 13: Hour of admission
12. Field 14: Type of admission/visit
13. Field 15: Admission source code
14. Field 16: Discharge hour (for maternity only)
15. Field 17: Patient discharge status
16. Fields 31-36: Occurrence information (accidents only)
17. Field 38: Responsible party’s name and address (if same as patient can
    indicate “same”)
18. Fields 39-41: Value codes and amounts
19. Field 42: Revenue code
20. Field 43: Revenue descriptions
21. Field 44: HCPCS/Rates/HIPPS Rate Codes
22. Field 45: Service/creation date (for outpatient services only)
23. Field 46: Service units
24. Field 47: Total charges
25. Field 50: Payer(s) information
26. Field 52: Information release
27. Field 53: Assignment of benefits
28. Field 56: PI
29. Field 58: Insured’s name
30. Field 59: Relationship of patient to insured
31. Field 60: Insured’s unique ID number
32. Field 62: Insurance group number(s) (only if group coverage)
33. Field 63: Prior authorization or treatment authorization number (if any)
34. Fields 65: Employer information (for Workers’ compensation claims only)
35. Field 66: ICD Version Indicator
36. Field 67: Principal diagnosis code
37. Field 69: Admitting diagnosis code (inpatient only)
38. Field 74: Principal procedure code and date (when applicable); and
39. Field 76: Attending physician’s name and ID (NPI or QUAL ID)

Providers must bill with current CPT-IV or HCPCS codes. Codes that have been deleted from CPT-IV or HCPCS are not recognized. When a miscellaneous procedure code is billed or a code is used for a service not described in CPT-IV or HCPCS, supportive documentation must be submitted with the claim.

Only submit claims after service is rendered. Claims submitted without the above mandatory information are not accepted and will be returned to the provider. In those cases, please fully complete and return the corrected claim with the Return to Provider Form within thirty (30) calendar days for processing.

Claims denied for incorrect or incomplete information must be resubmitted (with corrected information) on a Claim Action Request Form (“CARF”). Please resubmit the claim with a copy of the Anthem EOB/RA showing the claim denial. Return the claim for processing within thirty (30) calendar days of the denial notice. When submitting corrected information on a full, partially paid, or denied claim, an adjustment must be requested on a Claim Action Request Form, rather than submitting a new claim. (It’s recommended that you submit a corrected claim with the CARF). When an unpaid claim is returned to you with a cover letter stating that additional information is required for processing, please resubmit the corrected claim requested information (as appropriate) with a copy of the cover letter and a completed Claim Action Request Form. Return the corrected claim or requested information for processing within thirty (30) calendar days of the Anthem letter date. Please see the Claim Action Request Procedures section of this Manual for more information.

Pass Through Billing

All participating Anthem providers (or their employees) rendering services to Anthem’s Covered Individuals are required to bill Anthem directly for that service(s).

Note: an employee of a provider may be a: physician assistant, surgical assistant, advanced practice nurse, clinical nurse specialist, certified nurse midwife, or physical therapist, who is under the direct supervision of the ordering provider and the service is billed by the ordering provider. An employee is a person that receives a W-2 (as opposed to a 1099) from the participating
provider, and does not have their own provider or NPI number.

Examples of pass-through billing include but are not limited to:

A. Laboratory Services - providers should only bill for the component of the services they perform: technical, professional, or both.

B. **PAP Smear with Evaluation and Management (E/M) code:** Pap smear lab codes are not eligible for separate reimbursement when reported with E/M Codes. In most cases when a family physician, internist or obstetrician/gynecologist submits a cytopathology/pap smear code, they are not the physicians preparing and/or interpreting the Pap smear. Instead, they are the physicians who obtained the specimen. **The pathologist preparing and interpreting the cytopathology/pap smear must bill for this service separately.**
   - In order to bill for Pap smear codes such as CPT codes 88142 through 88154, 88164 through 88167, and 88174 through 88175, providers have to do the actual processing and screening.
   - Interpretation codes are 88141 and 88155, and may be billed in addition to the screening code, if the additional services are provided.

C. Physical Therapy Services – providers should only bill for those services that the physician or physical therapist employed by the physician performed. In order for the physical therapist to be considered an employee of the provider, the physical therapist must receive a W-2 from the provider (and not a 1099).

The following are not considered pass-through billing:

A. The service of the performing provider is performed at the place of service of the ordering provider, by an employee of the ordering provider, and is billed by the ordering provider.

B. One exception relates to services already reimbursed as a component of a DRG or per diem payment, so long as such services are not also billed by the servicing provider.

**Helpful Tips for Filing Claims**

**Other Insurance Coverage**

When filing claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the EOB from the other insurance coverage is attached to the claim:

**CMS-1500 Fields:**
Field 9: Other insured’s name
Field 9a: Other insured’s policy or group number
Field 9b: Other insured’s date of birth
Field 9c: Employer’s name or school name (not required in EDI)
Anesthesia Claims

When filing claims for anesthesia services (anesthesia codes 00100-01999), minutes—rather than units—must be billed.

- **Anesthesia Time Units** are reported in one minute increments and noted in the unit’s field.

- When **multiple surgical procedures** are done, only report the anesthesia code with the highest base value with the TOTAL time for all procedures. Multiple anesthesia codes will not be reimbursed. Effective on November 14, 2009 with ClaimsXten implementation, if multiple anesthesia codes are billed on the same date of service the line with the lowest charge will be denied.

- **Obstetrical epidural anesthesia** edits may occur when the reported anesthesia time exceeds 2.5 hours if the provider does not have a global contract. A maximum of 2.5 hours of anesthesia time is routinely allowed. Upon review, additional time units may be allowed with documentation that face-to-face time with the obstetrical patient exceeded 2.5 hours.

- When **billing surgery codes**, only bill one unit of service as time is not considered. Surgical codes are reimbursed based on the RVU for the surgical procedure times the surgical conversion factor.

- Procedure codes published in CPT Appendix G include **moderate sedation** (99143 and 99144) as global to performing the procedure and are not eligible for separate reimbursement. [See Reimbursement Policy: Moderate Sedation].

- **Moderate sedation** rendered by a provider who is not performing the diagnostic or therapeutic procedure is not eligible for reimbursement in a non facility setting such as a provider’s office or a clinic.

- **Modifier AA** should be reported in the last modifier position when other payment modifiers such as P3 are billed in order to assure additional allowance is added for the payment modifiers. (Modifier AA is not necessary as it is assumed unless there is a “Q” modifier to indicate otherwise.)

- If **more than one payment modifier** is billed, then modifier 99 should be billed in the first position to ensure all payment modifiers are applied. (Example: 99, QX, P3)

- For more information on Anesthesia services please see Reimbursement Policy Anesthesia.
Correct Coding for Preventive Colonoscopy

Anthem allows for preventive colonoscopy in accordance with state mandates. Colonoscopies which are undertaken as a SCREENING colonoscopy, during which a polyp/tumor or other procedure due to an abnormality are discovered, should be covered under benefits for Preventive Services. This has been an area of much confusion in billing by providers of services. Frequently the provider will bill for the CPT code with and ICD-9 diagnosis code corresponding to the pathology found rather than the “Special screening for malignant neoplasms, of the colon”, diagnosis code V76.51.

CMS has issued guidance on correct coding for this situation and states that the **V76.51 diagnosis code should be entered as the primary diagnosis** and that the ICD-9 diagnosis code for any discovered pathology should be entered as the 2ndary diagnosis on all subsequent claim lines.

Anthem endorses this solution for this coding issue as the appropriate method of coding to ensure that the provider receives the correct reimbursement for services rendered and that our members receive the correct benefit coverage for this important service.

Medical Records and Situations When Clinical Information Is Required

See the Medical Records and Situations When Clinical Information is Required Submission Guidelines on the last two pages of this section. **Please note requirement for records for prolonged attendance.**

Modifiers

For more information on modifiers, please see the Claims Editing Software Programs portion of this section and Reimbursement Policy: **Modifier Rules** on the secure provider portal, ProviderAccess.

Late Charges

Late charges for claims previously filed can be submitted electronically. You must reference the original claim number in the re-billed electronic claim. If attachments are required, please submit them on paper with the completed Claim Action Request Form.

Credits

For an original billing the total billed amount for each line must equal the total charges for the claim; therefore, don’t itemize credit dollar amounts If the original services were over-billed, please submit the correction on the Claim Action Request Form.
Negative Charges

When filing claims for procedures with negative charges, please don’t include these lines on the claim. Negative charges often result in an out-of-balance claim that must be returned to the provider for additional clarification.

Ambulatory Surgical Centers

When billing revenue codes, always include the CPT and HCPCS code (if applicable) for the surgery being performed. This code is required to determine the procedure, and including it on the claim helps us process the claim correctly and more quickly. Ambulatory surgical claims must be billed on a UB-04 CMS-1450 claims form.

Date of Current Illness, Injury or Pregnancy

For any 800-900 diagnosis codes, an injury date is required. For a pregnancy diagnosis, the date of the member’s last menstrual cycle is required to determine a pre-existing condition.

Type of Billing Codes

When billing facility claims, please make sure the type of bill coincides with the revenue code(s) billed on the claim. For example, if billing an outpatient revenue code, the type of bill must be for outpatient services.

Occurrence Dates

When billing facility claims, please make sure the surgery date is within the service from and to dates on the claim. Claims that include a surgical procedure date that falls outside the service from and to dates will be returned to the provider.

National Drug Codes (NDC)

All Providers and Facilities should supply the 11-digit NDC when billing for injections and other drug items on the CMS1500 and UB04 claim forms as well as on the 837 electronic transactions.

When Healthcare Common Procedure Coding System (HCPCS) codes, Current Procedural Terminology (CPT) codes, and revenue codes listed below are billed AND should include the following:

- The valid 11-digit NDC
- unit of measure qualifier and quantity including a decimal point for correct reporting;
- correct reporting of units for the HCPCS, CPT, or revenue code; and
- a valid HCPCS, CPT, or revenue code.
**Location of the NDC:**

The NDC is found on the label of a prescription drug item and must be included on the CMS-1500 or UB04 claim form or in 837 electronic transactions. The NDC is a universal number that identifies a drug or related drug item. The complete NDC number consists of 11 digits with hyphens separating the number into three segments in a 5-4-2 format such as “12345-1234-12.” **Do not enter any of the hyphens on claim forms.**

![NDC Example](image)

<table>
<thead>
<tr>
<th>NDC Number Section</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 (five digits)</td>
<td>Vendor/distributor identification</td>
</tr>
<tr>
<td>2 (four digits)</td>
<td>Generic entity, strength and dosage information</td>
</tr>
<tr>
<td>3 (two digits)</td>
<td>Package code indicating the package size</td>
</tr>
</tbody>
</table>

**Unit of Measurement Requirements:**

The unit of measurement codes are also required to be submitted. The codes to be used for all claim forms are:

- F2 – International unit
- GR – Gram
- ML – Milliliter
- UN – Unit

**Correcting Omission of a Leading Zero:**

Sometimes the NDC is printed on a drug item and a leading zero has been omitted in one of the segments. Instead of the digits and hyphens being in a 5-4-2 format, the NDC might be printed in a 4-4-1 format (example, 1234-1234-1), a 5-3-2 format (example, 12345-123-12), or a 5-4-1 format (example, 12345-1234-1).

- **If this occurs,** when entering the NDC on the claim form, it will be required to add a leading zero or zeros at the beginning of the NDC, ensuring the NDC consists of eleven (11) digits.
- **Ensure any added zeros are only added to the beginning of the NDC.**
- **Do not enter any of the hyphens on claim forms.**
See the examples that follow:

<table>
<thead>
<tr>
<th>If the NDC appears as…</th>
<th>Then the NDC…</th>
<th>And it is reported as …</th>
</tr>
</thead>
<tbody>
<tr>
<td>NDC 12345-1234-12</td>
<td>Is complete</td>
<td>12345123412</td>
</tr>
<tr>
<td>(5-4-2 format)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDC 1234-1234-12</td>
<td>Needs a leading zero placed at the beginning of the NDC.</td>
<td>01234123412</td>
</tr>
<tr>
<td>(4-4-1 format)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NDC 12345-1234-1</td>
<td>Needs a leading zero placed at the beginning of the NDC</td>
<td>01234512341</td>
</tr>
<tr>
<td>(5-4-1 format)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Process for Multiple NDC numbers for Single HCPC Codes:**

- If there is more than one NDC within the HCPCs code, you must submit each applicable NDC as a separate claim line. Each drug code submitted must have a corresponding NDC on each claim line.
- If the drug administered is comprised of more than one ingredient (i.e. compound or same drug with different strength, etc.), you must represent each NDC on a claim line using the same drug code.
- Standard HCPCs billing accepts the use of modifiers to determine when more than one NDC is billed for a service code. They are:
  - KP – First drug of a multiple drug unit dose formulation
  - KQ – Second or subsequent drug of a multiple drug unit dose formulation
  - SH – second or concurrently administered infusion therapy
  - SJ – third or more concurrently administered infusion therapy

**How/Where to Place the NDC on a Claim Form:**

*(CMS 1500 Claim Form)*

- Reporting the NDC requires using the upper **and** lower rows on a claim line. Be certain to line up information accurately so all characters fall within the proper box and row.
- **DO NOT** bill more than one NDC per claim line.
- Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the claim form.
- If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
- The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.
The following table provides elements of a proper NDC entry on a CMS-1500 claim form.

<table>
<thead>
<tr>
<th>How</th>
<th>Example</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter a valid revenue code</td>
<td>NDC 00054352763</td>
<td>Beginning at left edge, enter NDC in the shaded area of box 24A</td>
</tr>
<tr>
<td></td>
<td>is entered as N400054352763</td>
<td></td>
</tr>
<tr>
<td>Enter one of four (4) unit of measure qualifiers;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• F2 – International Unit</td>
<td>GR0.045</td>
<td>Immediately following the 11-digit NDC, enter 3 spaces, followed by one of four (4) unit of measure qualifiers, followed immediately by the quantity</td>
</tr>
<tr>
<td>• GR - Gram</td>
<td>ML1.0</td>
<td></td>
</tr>
<tr>
<td>• ML - Milliliter</td>
<td>UN1.000</td>
<td></td>
</tr>
<tr>
<td>• UN - Units</td>
<td></td>
<td></td>
</tr>
<tr>
<td>and quantity, including a decimal point for correct reporting</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Enter a valid HCPCS or CPT code</td>
<td>J0610 “Injection Calcium Gluconate, per 10 ml” is billed as 1 unit for each 10 ml ampul used</td>
<td>Non-shaded area of box 24D</td>
</tr>
</tbody>
</table>
• Even though an NDC is entered, a valid HCPCS or CPT code must also be entered in the claim form.
• If the NDC you bill does not have a specific HCPCS or CPT code assigned, please assign the appropriate miscellaneous code per Correct Coding Guidelines.
• DO NOT bill more than one NDC per claim line.
• The unit of service for the HCPCS or CPT code is very important. Units for injections must be billed consistent with the HCPCS or CPT description of the code.

The following table provides elements of a proper NDC entry on a UB04 claim form.

<table>
<thead>
<tr>
<th>How</th>
<th>Example</th>
<th>Where</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter a valid revenue code</td>
<td>Pharmacy Revenue Code 0252</td>
<td>Form locator (box) 42</td>
</tr>
<tr>
<td>Enter 11- digit NDC</td>
<td>NDC 00054352763</td>
<td>Beginning at left edge, enter NDC in locator (box) 43 currently labeled as “Description”</td>
</tr>
</tbody>
</table>
| Enter one of four (4) unit of measure qualifiers;  
  • F2 – International Unit  
  • GR - Gram  
  • ML - Milliliter  
  • UN - Units and quantity, including a decimal point for correct reporting | GR0.045 ML1.0 UN1.000 | Immediately following the 11 digit NDC, enter 3 spaces followed by one of four (4) unit of measure qualifiers, followed immediately by the quantity. |
Enter a valid HCPCS or CPT Code
J0610 “injection Calcium, per 10ML” is billed as 1 unit for each 10ML ampul used
Form locator (box 44)

Sample Images of the UB04 Claim Form:

837 P And 837 I Reporting Fields:

Billing or Software Vendor:
You will need to notify your billing or software vendor that the NDC is to be reported in the following fields in the 837 format:

<table>
<thead>
<tr>
<th>LOOP</th>
<th>Segment</th>
<th>Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>2410</td>
<td>LIN 03</td>
<td>Place the 11 digit NDC here</td>
</tr>
</tbody>
</table>

Claims Submissions for Pharmaceuticals
Provider and Facility agree to submit the national drug code (NDC) on claims submitted for FDA approved prescription medications.

Present on Admission (“POA”)
This section applies to acute care inpatient hospital claims with bill types of 11X or 12X.

Paper Claims
On the UB04, the POA indicator is the eighth digit of Field Locator (“FL”) 67, principal diagnosis, and the eighth digit of each of the secondary diagnosis fields, FL 67 A-Q. Report the applicable POA indicator (Y, N, U, or W) for the principal and any secondary diagnoses and include this as the eighth digit; leave this field blank if the diagnosis is exempt from POA reporting. **Claims submitted with an invalid POA indicator will be returned to the submitter.**

Y — Diagnosis was present at time of inpatient admission
N — Diagnosis was not present at time of inpatient admission
U — Documentation insufficient to determine if condition was present at the time of inpatient admission
W — Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission
1 — Exempt from POA reporting. This code is the equivalent code of a blank on the UB-04, however, it was determined that blanks were undesirable on Medicare claims when submitting this data via the 004010/00410A1

National Provider Identifier

The National Provider Identifier (“NPI”) is one provision of the Administrative Simplification section of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Anthem requires the NPI (as your only provider identifier) on electronic and paper transactions.

Location of the NPI on claim forms

NPI location for electronic transactions:

• The NPI will be reported in the provider loops on electronic transactions. The following elements are required:
  - The NM108 qualifier will be “XX” for NPI submission.
  - The NM109 field will display the 10-digit NPI.
  - The TIN will be required in the Ref segment when the NPI is reported in the NM109.
  - The REF01 qualifiers (EI = TIN; SY = Social Security number)
  - The REF02 field will display the provider’s or facility’s TIN or Social Security number.

• The chart below outlines the changes for 837 professional, institutional and dental claims:

<table>
<thead>
<tr>
<th>Field</th>
<th>Locator</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Identifier Qualifier</td>
<td>NM108 qualifier</td>
<td>Key “XX” for NPI submission.</td>
</tr>
<tr>
<td></td>
<td>NM109 field</td>
<td>Key the 10-digit NPI. (The tax ID number will be required in the Ref segment when the NPI is reported in the NM109 locator.) This requirement of Tax ID will be on Billing, Pay to, and rendering provider loops only.</td>
</tr>
<tr>
<td>Secondary Identifier Qualifier</td>
<td>REF01 qualifiers</td>
<td>Key “EI” (tax ID) or “SY” (Social Security number).</td>
</tr>
<tr>
<td>Secondary Identifier</td>
<td>REF02</td>
<td>Key the provider tax ID number or Social Security number.</td>
</tr>
<tr>
<td>Other Identifier not</td>
<td>REF01</td>
<td>Key “LU” (location number), “0B” (state license number)</td>
</tr>
<tr>
<td>considered legacy IDs Optional</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Identifier not</td>
<td>REF02</td>
<td>Key the location number or state license</td>
</tr>
</tbody>
</table>
### Field Locator Changes

| Field considered legacy IDs | Locator Optional | Changes number |

#### NPI location on the electronic remittance advice (835):

<table>
<thead>
<tr>
<th>Loop/Segment</th>
<th>Institutional</th>
<th>Professional</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loop 1000B; N103</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>Loop 1000B; N104</td>
<td>NPI</td>
<td>NPI</td>
</tr>
<tr>
<td>Loop 1000B; REF01</td>
<td>TJ</td>
<td>TJ</td>
</tr>
<tr>
<td>Loop 1000B; REF02</td>
<td>TIN</td>
<td>TIN</td>
</tr>
<tr>
<td>Loop 2000; TS301</td>
<td>Not used</td>
<td>Not used</td>
</tr>
<tr>
<td>Loop 2100; NM108</td>
<td>XX</td>
<td>XX</td>
</tr>
<tr>
<td>Loop 2100; NM109</td>
<td>NPI</td>
<td>NPI</td>
</tr>
</tbody>
</table>

#### NPI location on paper forms:

- Revised CMS-1500 (08/05)
  - The NPI will be displayed in box/field 17b for the **referring** provider.
  - The NPI will be displayed in box/field 24j for the **rendering** provider.
  - Locators 32a and 33a are also designated for the NPI for the **servicing** provider locations and pay to/billing provider location.
**NPI location on paper forms:**

- UB-04 CMS-1450
  - The NPI will be displayed in the following boxes/fields:
    - Box/field 56 for the **facility**
    - Box/field 76 for the **attending physician**
    - Box/field 77 for the **operating physician**
    - Box/fields 78 and 79 for **other provider** type (optional)

---

**Timely Filing**

**Timely Filing for Claims**

Claims must be submitted within the timely filing timeframe specified in your contract.

All additional information reasonably required by Anthem to verify and confirm the services and charges must be provided on request. The provider must complete and return requests for additional information within thirty (“30”) calendar days of Anthem’s request.

*Claims submitted after the timely filing period expires will be denied, unless proof of timely filing can be demonstrated according to the guideline listed below.*
Submission of Claims under the Federal Employee Health Benefit Program (aka Federal Employee Program)

All claims under the Federal Employee Health Benefit Program (“FEHBP”) aka Federal Employee Program (“FEP”) must be submitted to Plan for payment within three hundred and sixty five (365) days from the date the Health Services are rendered. Providers and Facilities agree to provide to Plan, at no cost to Anthem or member all information necessary for Plan to determine its liability, including, without limitation, accurate and Complete Claims for Covered Services, utilizing forms consistent with industry standards and approved by Plan or, if available, electronically through a medium approved by Plan. If Plan is the secondary payer, the three hundred and sixty five (365) day period will not begin to run until Provider or Facility receives notification of primary payer’s responsibility. Plan is not obligated to pay claims received after this three hundred and sixty five (365) day period. Except where the member did not provide Plan ID, Provider or Facility shall not bill, collect or attempt to collect from member 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.

Proof of Timely Filing

Waiver of the timely filing requirement is only permitted when Anthem has received documentation indicating the member or provider originally submitted the claim within the applicable timely filing period.

The documentation submitted must indicate the claim was originally submitted before the timely filing period expired.

Acceptable documentation includes the following:

1. A copy of the claim with a **computer-printed filing date** (a handwritten date isn’t acceptable)

2. An original fax confirmation specifying the claim in question and including the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service

3. The provider’s billing system printout showing the following information: date of service, amount billed, member name, original date filed with Anthem and description of the service
If the provider doesn’t have an electronic billing system, approved documentation is a copy of the member’s chart indicating the billed date and/or a copy of the billing records indicating the billed date, and the information listed above.

4. If the claim was originally filed electronically, a copy of Anthem’s electronic Level 2 or your respective clearinghouse’s acceptance/rejection claims report is required; a copy can be obtained from the provider’s EDI vendor, EDI representative or clearinghouse representative. The provider also must demonstrate that the claim and the member’s name are on the original acceptance/rejection report. Note: When referencing the acceptance/reject report, the claim must show as accepted to qualify for proof of timely filing. Any rejected claims must be corrected and resubmitted within the timely filing period.

5. A copy of the Anthem letter requesting additional claim information showing the date information was requested.

If the provider originally received incorrect insurance information, the provider has thirty (30) calendar days from the date the provider is advised of the correct insurance information to file the claim with the correct carrier.

Appeals for claims denied for failing to meet timely filing requirements must be submitted to Anthem in writing. Anthem doesn’t accept appeals over the phone.

Any exceptions to the proof of timely filing policy require the signature of the person in the director-level position or above in the applicable Anthem department.

Please send all claims data to the applicable address listed in the Alpha Prefix Reference List section.

Electronic Data Interchange (“EDI”)

EDI allows Providers and Facilities 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 HIPAA compliant and is a strong proponent of EDI transactions because they will significantly reduce administrative and operating costs, 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 Manual includes the 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**

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](http://www.anthem.com/edi).

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.

- To view the Companion Guide, visit [anthem.com/edi](http://anthem.com/edi), select state, click on Documents tab, then [HIPAA Companion Guide](https://www.anthem.com/edi).

**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
- Billing 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
- FAQs 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.

**Contact the EDI Solutions Helpdesk**

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

- Business hours: 8:00 a.m. – 4:30 p.m. Mountain Time Monday - Friday
- Phone: 800-332-7575
- Fax: 888-438-7965
- E-mail: edi-nv@anthem.com
- Website/Live Chat: [www.anthem.com/edi](http://www.anthem.com/edi)

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

**Submitting and Receiving EDI Transactions**

Visit our web site [www.anthem.com/edi](http://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’s or Facility’s 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 a 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 provider 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, or if directed to contact Anthem, (2) contact our EDI Solutions Helpdesk with reports, password re-set or any other related issues to electronic transactions.

- Clearinghouse or vendor: 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 (EOBs).

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 web site at www.anthem.com/edi and refer to our HIPAA Anthem 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 member ID number, including the three character alpha prefix
- Covered Individual’s name as it appears on the Covered Individual’s identification card, for supplemental insurance

Reduce Duplicate Billing:

- Do not file with us and Medicare simultaneously.
• Wait until you receive the Explanation of Medicare Benefits ("EOMB") or payment advice from Medicare.

• Payment from supplemental insurers should, as a rule, occur only after the Medicare payment has been issued. The Centers for Medicare & Medicaid Services ("CMS") requests that you do not bill your patients' supplemental insurers for a minimum of fifteen (15) business 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" or "N89" 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 receives appropriate training on report functions.

You can find Anthem report descriptions, along with formatting specifications, error listings and troubleshooting tips online in our HIPAA Companion Guide. Go to anthem.com/edi, select state, click on Documents tab, then HIPAA 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 time 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 the EDI Solutions Help Desk 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 payers like Anthems.

**How to enroll for ERA:**

Download the ERA enrollment form from our web site or refer to the HIPAA Companion Guide for additional details. Go to [anthem.com/edi](http://anthem.com/edi), select state, and click on the Register tab, Registration Forms, then Electronic Remittance/Electronic Funds Transfer Registration Form.

**Electronic Funds Transfer (EFT):**

Anthem offers EFT, a secure process for directly depositing payments into the providers’ bank accounts. To enroll for EFT download the EFT request form from our web site at [www.anthem.com/edi](http://www.anthem.com/edi). (See form listed above for ERA. While the form is the combined to include both ERA and EFT, you are not required to sign up for both) Submit the completed form along with the required banking information by fax or mail using the instructions on the request form.

**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 Registration form referenced above.
### EDI/EFT Contact

<table>
<thead>
<tr>
<th>Enrollment or vendor changes, File Delivery and Formatting</th>
<th>EDI Vendor</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>EDI Solutions Help Desk</td>
</tr>
<tr>
<td></td>
<td>- Business hours: 8:00 a.m. – 4:30 p.m. Mountain Time Monday - Friday</td>
</tr>
<tr>
<td></td>
<td>- Phone: 800-332-7575</td>
</tr>
<tr>
<td></td>
<td>- Fax: 888-438-7965</td>
</tr>
<tr>
<td></td>
<td>- E-mail: <a href="mailto:edi-nv@anthem.com">edi-nv@anthem.com</a></td>
</tr>
<tr>
<td></td>
<td>- Website/Live Chat: <a href="http://www.anthem.com/edi">www.anthem.com/edi</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ERA – Claim adjudication, payment and remark codes</th>
<th>Provider Customer Service: 877-833-5742</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFT – Bank Posting, Payment Delivery/Amount Questions</td>
<td>EDI Solutions Help Desk: 800-332-7575</td>
</tr>
</tbody>
</table>

| Anthem Delivery Schedule, File Layout and Field Definition | Anthem HIPAA Companion Guide available at anthem.com/edi. Select state, then Documents tab, and HIPAA Companion Guide, Transaction Specific Companion Documents, then 835 Health Care Claim Payment/Remittance Advice |

### Real Time Electronic Transactions

The Real Time transactions include:

- **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 Providers and Facilities access to Covered Individual 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 Covered Individual eligibility, coverage verification, and patient liability (deductible, co-payment, 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 specialists.

**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 learn more about options available.
- For connectivity options and file specification our HIPAA Companion Guide is available at [www.anthem.com/edi](http://www.anthem.com/edi).

**Getting Connected with Electronic Attachments**

Anthem accepts Claims attachments electronically (when submitted with the original Claims) such as medical records, admission summaries, physician orders, diagnostic reports, radiology films and other types of claims attachments via a vendor. To take advantage of electronic attachments when filing electronic Claims to Anthem, contact Medical Electronic Attachments, Inc. (MEA) at 888-329-9988 ext. 2.

**Explanation of Benefits ("EOB") and Remittance Advice ("RA")**

The EOB or RA will include the information needed to post claims for each member included during this processing cycle. Anthem will send one check to cover the total amount on the EOB/RA. To receive your EOBs/RAs electronically, please call 800-332-7575, or download the 835 registration form at [anthem.com/edi](http://anthem.com/edi), select state.

EOBs and RAs are in the same format for all local and BlueCard members. See the sample EOB and RA below.
Anthem Blue Cross and Blue Shield Provider Manual – NV

EXPLANATION OF BENEFITS

<table>
<thead>
<tr>
<th>ISSUE DATE</th>
<th>PAGE</th>
<th>C000002</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 26, 2006</td>
<td>000002</td>
<td>OF 00003</td>
</tr>
</tbody>
</table>

Sequence Number: 232763722
Provider ID: 232763722
NETWORK PROVIDER: N
FOUNDATION PHYSICIAN: N

### Alpha Prefix

**Patient Name:** DOE, JOHN
**Claim ID:** 0812911689
**ID Number:** AAA031A0610
**Acct Nbr:**
**Group Nbr:** CU0200

<table>
<thead>
<tr>
<th>SERVICE DATE(s)</th>
<th>PROCEDURE NUMBER</th>
<th>UNITS OF SERVICE</th>
<th>BILLED AMOUNT</th>
<th>ALLOWED AMOUNT</th>
<th>NOT ALLOWED AMOUNT</th>
<th>DEDUCTIBLE AMOUNT</th>
<th>COINSURANCE</th>
<th>COPAYMENT AMOUNT</th>
<th>CLAIMS PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/12/06</td>
<td>90921</td>
<td>001</td>
<td>650.00</td>
<td>364.82</td>
<td>285.18/01</td>
<td>141.93/02</td>
<td>141.93</td>
<td>212.89</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL THIS CLAIM:** 650.00 364.82 285.18 0.00 141.93 212.89

**MESSAGES:**
01 - This is the amount in excess of the allowed expense for a non-participating provider.
02 - This balance is the member's coinsurance responsibility.

**PAYMENT SUMMARY**

<table>
<thead>
<tr>
<th>CLAIMS PAYMENT/ADJUSTMENTS</th>
<th>PROCESSED</th>
<th>PAID AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Claims</td>
<td>212.89</td>
<td>212.89</td>
</tr>
<tr>
<td>Adjustments Payable Provider</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Deferred Adjustments Due</td>
<td>0.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Sub Total</td>
<td></td>
<td>212.89</td>
</tr>
</tbody>
</table>

**CHECK AMOUNT (CHK # 7000004038):** $212.89

**THIS IS NOT A BILL**

SEE LAST PAGE FOR IMPORTANT INFORMATION

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.

* Registered Marks Blue Cross and Blue Shield Association.
**EOB Data Dictionary**

The following list provides definitions for all data fields in the EOB, which we send to providers who submit claims on a CMS-1500 Form.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Account Number</td>
<td>The account number your office has assigned to our member’s account. This number will be repeated on each claim/EOB.</td>
</tr>
<tr>
<td>Adjustment Information</td>
<td>This line follows the claim detail and indicates if the claim is an adjustment. If it’s an adjustment, the original claim’s EOB sequence number is cross-referenced.</td>
</tr>
<tr>
<td>Adjustments Payable (to the) Provider</td>
<td>A supplemental adjustment that will increase the Anthem paid amount for a claim and will be added to the current EOB</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>The schedule of maximum allowable amounts</td>
</tr>
<tr>
<td>Billed Amount</td>
<td>The amount the provider billed Anthem for the service</td>
</tr>
<tr>
<td>Claim ID</td>
<td>The document control number (DCN), which is the number Anthem assigns for each claim, document and letter which is received by Anthem. The first five numbers are the Julian date.</td>
</tr>
<tr>
<td>Claims Payment</td>
<td>The allowed amount minus the deductible amount minus the coinsurance/copayment amount, i.e., the allowed amount minus the member’s financial responsibility</td>
</tr>
<tr>
<td>Claims Payment/Adjustments</td>
<td>A summary of all the claims and adjustments from the previous pages of the EOB found in the Payment Summary box on the last page of the EOB</td>
</tr>
<tr>
<td>Claim Received Date</td>
<td>The date Anthem received the original claim – (which is the same as the DCN date)</td>
</tr>
<tr>
<td>Coinsurance/Copayment Amount</td>
<td>The amounts, which are determined by the member’s Health Benefit Plan, that the member must pay</td>
</tr>
<tr>
<td>Deductible Amount</td>
<td>The amount, which is determined by the member’s Health Benefit Plan, that the member must pay before benefit payments begin</td>
</tr>
<tr>
<td>Deferred Adjustments Due</td>
<td>Adjustment(s) indicated on the current EOB. The indicated amount(s) will be withheld from an EOB 30 days from the current EOB date – not from this EOB. (Note: this amount is not taken from this RA, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.)</td>
</tr>
<tr>
<td>Deferred Claims Adjustment Withhold</td>
<td>A list of any overpayment(s) being deducted from the current payment. Each claim is itemized and includes the member’s name, account number, service dates, sequence number, reason code, withhold amount and the telephone number to call for inquiries. (Note: a sequence number will be displayed referring to the original RA where the notification occurred titled “Deferred Adjustment Due”).</td>
</tr>
<tr>
<td>ID Number</td>
<td>The member’s unique Anthem ID number, which has an alpha character in the fourth position (Note: all local members’ ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member’s only, alpha prefix is not included on the EOB)</td>
</tr>
</tbody>
</table>
OUTPATIENT

<table>
<thead>
<tr>
<th>PATIENT ACCT NUMBER</th>
<th>PATIENT NAME</th>
<th>CONTRACT TYPE</th>
<th>SERVICE DATES FROM TO</th>
<th>APPROVED DAYS</th>
<th>TOTAL CHARGES</th>
<th>PROVIDER LIABILITY</th>
<th>CLAIMS PAID AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>734714-0001</td>
<td>DOE, J.</td>
<td>PREX</td>
<td>05/26/06 - 06/26/06</td>
<td>000</td>
<td>602.00</td>
<td>409.64</td>
<td>119.16</td>
</tr>
<tr>
<td>06157058547</td>
<td>JONES, J.</td>
<td>PREX</td>
<td>05/25/06 - 05/26/06</td>
<td>000</td>
<td>173.05</td>
<td>127.05</td>
<td>114.35</td>
</tr>
<tr>
<td>720000-0001</td>
<td>WILSON, W</td>
<td>IPSE</td>
<td>04/20/06 - 04/20/06</td>
<td>000</td>
<td>363.40</td>
<td>21.40</td>
<td>0.00</td>
</tr>
</tbody>
</table>

EXPLANATION OF CODES

<table>
<thead>
<tr>
<th>CONTRACT TYPES:</th>
<th>NETWORK:</th>
<th>ACTION CODES:</th>
</tr>
</thead>
<tbody>
<tr>
<td>COE: Premier $25</td>
<td>NW01 ANTHEM</td>
<td></td>
</tr>
<tr>
<td>COEE: $35 Genrx</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COSL: BP Opt I 15/40/60/30%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COED: $40 Copay</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COEIA: Premier $15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>COEGI: H S A 2000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

THIS IS NOT A BILL

Anthem Blue Cross and Blue Shield is the trade name of Rocky Mountain Hospital and Medical Service, Inc.

Registered Marks Blue Cross and Blue Shield Association.
RA Data Dictionary

The following list provides definitions for all data fields in the RA, which we send to providers who submit claims on a UB-04 CMS-1450 Form.

| **Action Code** | A three-digit code indicating the final outcome of the claim. If the claim is paid, “PAID” will display. A list of applicable codes is provided in the RARA explanation of codes section. |
| **Approved Days** | Inpatient days approved by utilization review. For **outpatient** days, approved days will be displayed as “000.” |
| **Check Amount** | The total amount paid for the claims listed in the RA. |
| **Claim Number** | The unique document control number (DCN), which is the number Anthem assigns for each claim received. The first five numbers are the Julian date. |
| **Claims Paid Amount** | The total amount to be paid to the provider for each claim listed on the RA. |
| **Claims Payments/Adjustments** | A summary of payments and adjustments for all inpatient and outpatient claims detailed in the RA. |
| **Contract Type** | The type of Anthem coverage the member has. A list of contract types for claims in the specific RA is displayed in the explanation of codes section. |
| **Covered Charges** | The maximum allowed amounts for the services covered by the member’s Health Benefit Plan. |
| **Deferred Claims Adjustment Withhold** | Any overpayment adjustment withholds that have not been repaid to Anthem within the 30-day timeframe. Each claim is itemized and includes information about the overpayment adjustment withhold. The RA check will be reduced by the amount(s) identified in this section.  
(Note: a sequence number will be displayed referring to the original RA where the notification occurred titled “Deferred Inpatient/Outpatient Adjustment Due”). |
| **Deferred Inpatient Adjustments Due** | The amount of overpayment adjustment for an inpatient claim identified on the RA. This amount is deferred for 30 days and notification letters are sent to the provider.  
(Note: this amount is not taken from this RA, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.) |
| **Deferred Outpatient Adjustments Due** | The amount of overpayment adjustment for an outpatient claim identified on the RA. This amount is deferred for 45 days and notification letters are sent to the provider.  
(Note: this amount is not taken from this RA, but will be taken from a future remittance as a “Deferred Claims Adjustment Withhold” if the overpayment is not received within the 30 day time period.) |
<p>| <strong>Explanation of Codes</strong> | Definitions for the contract types, networks utilized and action codes listed in the claim detail line information of the RA and displayed on the second-to-last page of the RA. |
| <strong>Payment Summary</strong> | The last page of the RA, which displays the summary breakdown of payments, adjustments, overpayment adjustment withholds and interest payments. |</p>
<table>
<thead>
<tr>
<th><strong>Inpatient Adjustments</strong></th>
<th>The total amount of all inpatient claims adjustments identified on the RA that are to be credited to the provider.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Payable Provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Issue Date</strong></td>
<td>The date the RA was generated.</td>
</tr>
<tr>
<td><strong>Member ID number</strong></td>
<td>The member’s unique Anthem ID number. The unique ID is a series of nine characters with a letter in the fourth position. (Note: all local members’ ID numbers include a 3 character alpha prefix which is part of their member ID number. For local member’s only, alpha prefix is not included on the EOB)</td>
</tr>
<tr>
<td><strong>Member Liability</strong></td>
<td>The amount (which is determined by the member’s Health Benefit Plan) the member must pay before benefit payments begin including copayments/coinsurance, deductible, and non-Covered Services.</td>
</tr>
<tr>
<td><strong>Network</strong></td>
<td>The grouping of health care providers Anthem contracts with to provide health care services to our members.</td>
</tr>
<tr>
<td><strong>Network Claim NBR</strong></td>
<td>Not currently used in the RA.</td>
</tr>
<tr>
<td><strong>Outpatient Adjustments</strong></td>
<td>The total amount of all outpatient claim adjustments identified on the RA that are to be credited to the provider.</td>
</tr>
<tr>
<td><strong>Payable Provider</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Paid Amount</strong></td>
<td>The total amounts to be paid for each of the following categories:</td>
</tr>
<tr>
<td></td>
<td>• Total inpatient claims</td>
</tr>
<tr>
<td></td>
<td>• Inpatient adjustments payable to the provider</td>
</tr>
<tr>
<td></td>
<td>• Total outpatient claims</td>
</tr>
<tr>
<td></td>
<td>• Outpatient adjustments payable to the provider</td>
</tr>
<tr>
<td></td>
<td>This column does not include the deferred inpatient or outpatient adjustments due amounts, because the overpayment adjustment is deferred for 30 days.</td>
</tr>
<tr>
<td><strong>Paid Days</strong></td>
<td>The total number of days for which the claim was paid, which is usually equal to or less than the approved days for inpatient claims. For outpatient claims, “1” will usually be indicated, unless the total “occurrences” for the particular procedure is indicated.</td>
</tr>
<tr>
<td><strong>Patient Account Number</strong></td>
<td>A patient identifier issued by the provider for its in-house records and captured only if submitted by the provider.</td>
</tr>
<tr>
<td><strong>Patient Name</strong></td>
<td>The last name and first initial of the patient for whom the claim was submitted.</td>
</tr>
<tr>
<td><strong>Processed</strong></td>
<td>The total amounts identified in the RA for each of the following categories:</td>
</tr>
<tr>
<td></td>
<td>• Total inpatient claims</td>
</tr>
<tr>
<td></td>
<td>• Inpatient adjustments payable to the provider</td>
</tr>
<tr>
<td></td>
<td>• Deferred inpatient adjustments due</td>
</tr>
<tr>
<td></td>
<td>• Total outpatient claims</td>
</tr>
<tr>
<td></td>
<td>• Outpatient adjustments payable to the provider</td>
</tr>
<tr>
<td></td>
<td>• Deferred outpatient adjustments due</td>
</tr>
<tr>
<td></td>
<td>A total isn’t indicated for this column because it only identifies the activity of the RA.</td>
</tr>
<tr>
<td><strong>Provider Liability</strong></td>
<td>The amount of write-off, based on the provider’s contractual agreement with Anthem.</td>
</tr>
<tr>
<td><strong>Refer to Seq. No. ___</strong></td>
<td>An identifier in the body of the RA that a claim adjustment occurred and which is a reference number to the previous RA where the original claim was processed.</td>
</tr>
<tr>
<td><strong>Reimbursement Rate</strong></td>
<td>The percentage(s), Per Diem amount or a flat-dollar amount at which the claim is reimbursed for the service or procedure.</td>
</tr>
<tr>
<td><strong>Remittance Advice</strong></td>
<td>A reimbursement report with detailed line information and a payment summary and issued electronically or on paper from Anthem’s claims processing system.</td>
</tr>
<tr>
<td>----------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Rsn Cde</strong></td>
<td>A three-digit reason code indicating the outcome of the claim and which is the same as the action code but identified as a reason code for deferred claims adjustment withholds. The reason code definition is displayed below the withhold information.</td>
</tr>
<tr>
<td><strong>Sequence Number</strong></td>
<td>A series of numbers assigned to each RA that include the Medicare number or TID number, the current year, and a sequential number following the year (e.g., sequence number 200400004 indicates it’s the fourth RA generated for the provider in the year 2004). The sequence number restarts at the beginning of each year.</td>
</tr>
<tr>
<td><strong>Service Dates</strong></td>
<td>The to/from dates indicated for an overpayment adjustment withhold in the financial summary.</td>
</tr>
<tr>
<td><strong>Service Dates From/To</strong></td>
<td>The dates of service for the claim.</td>
</tr>
<tr>
<td><strong>Service Type</strong></td>
<td>Indicates whether the claim is for inpatient or outpatient services in the deferred claims adjustment withhold section of the financial summary.</td>
</tr>
<tr>
<td><strong>Statutory Interest on Delayed Payment</strong></td>
<td>An interest payment from the processing date for a claim not paid within the required timeframe.</td>
</tr>
<tr>
<td><strong>Subtotal</strong></td>
<td>The total amount Anthem is paying for the claims listed in the RA.</td>
</tr>
<tr>
<td><strong>Total Charges</strong></td>
<td>The amount the provider bills for the service or procedure.</td>
</tr>
<tr>
<td><strong>Total Inpatient Claims</strong></td>
<td>The initial inpatient claims total listed in the RA and which does not include any adjustment amounts identified in the RA.</td>
</tr>
<tr>
<td><strong>Total Outpatient Claims</strong></td>
<td>The initial outpatient claims total listed in the RA and which does not include any adjustment amounts identified in the RA.</td>
</tr>
<tr>
<td><strong>Withhold Amount</strong></td>
<td>The amount of the overpayment adjustment withhold that will be deducted from the RA check total.</td>
</tr>
</tbody>
</table>
Provider EOB/RA Frequently Asked Questions

Reference our online Provider Toolkit for information on frequently asked questions about our EOBs and RAs. Find out answers to common questions about:

- Miscellaneous “take backs”
- Notice of a “take back” vs. an actual “take back”
- Zero-pay voucher

Access our Provider Toolkit information online. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Provider Toolkit, and “Provider EOB/RA Frequently Asked Questions”.

Situations When Clinical Information Is Required

The following claims categories may routinely require submission of clinical information before or after payment of a claim:

- Claims involving pre-certification/prior authorization/pre-determination or some other form of utilization review, including, but not limited to the following:
  - Claims pending for lack of pre-certification or prior authorization
  - Claims involving Medical Necessity or experimental/investigational determinations
  - Claims for pharmaceuticals that require prior authorization
- Claims involving certain modifiers, including, but not limited to, modifier 22
- Claims involving unlisted codes
- Claims for which Anthem can’t determine, from the face of the claim, whether it involves a covered service and therefore can’t make the benefit determination without reviewing medical records (examples include, but aren't limited to, pre-existing condition issues, emergency service-prudent layperson reviews and specific benefit exclusions)
- Claims Anthem has reason to believe involve inappropriate (including fraudulent) billing
- Claims, including high-dollar claims, that are the subject of an internal or external audit
- Claims for members involved in case management or disease management
- Claims that have been appealed or are otherwise the subject of a dispute, including claims being mediated, arbitrated or litigated
- Other situations in which clinical information may routinely be requested:
  - Requests related to underwriting, including, but not limited to, member or physician misrepresentation/fraud reviews and stop-loss coverage issues
  - Accreditation activities
- Quality improvement/assurance activities
- Credentialing
- Coordination of benefits
- Recovery/subrogation

Examples provided in each category are for illustrative purposes only and aren’t meant to represent an exhaustive list within the category.
Medical Records Submission Guidelines

Submission of Medical Records for Claims (applies to both EDI and paper claims)

Medical records are required for items 1 through 8 below and must be submitted with the claim to help ensure prompt payment of the claim.

1. All miscellaneous HCPCS and CPT codes
2. All miscellaneous J**** codes
3. All IV therapy drugs and home infusion
4. Remicade, Synagis, Synvisc
5. Change of diagnosis (diagnosis code)
6. Unlisted procedures
7. All DME HCPCS codes
8. Surgery codes with Modifier 22

Please note: This list doesn’t apply to inpatient facility services.

- If medical records aren’t required per the above list, please don’t submit records with the claim.
- If medical records are required, please refer to the next section to determine the type of record you must submit.
  - EDI submitted claims would include the “PWK” Paperwork Included segment to let our processors know there is an attachment/documentation included for this claim.
- Medical records previously submitted as part of pre-certification (pre-service review) may meet the requirements for medical records. Please review “Types of Medical Records Required” below.

Types of Medical Records Required (for items 1 through 7 above)

<table>
<thead>
<tr>
<th>CPT Codes</th>
<th>Medical Record Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>99000 – 99999</td>
<td>Detailed description of services</td>
</tr>
<tr>
<td>01999</td>
<td>Anesthesia record</td>
</tr>
<tr>
<td>10000 – 69999</td>
<td>Operative report or detailed description of services</td>
</tr>
<tr>
<td>70000 – 79999</td>
<td>X-ray report or detailed description of services (operative report)</td>
</tr>
<tr>
<td>80000 – 89999</td>
<td>Lab report or documentation of Medical Necessity</td>
</tr>
<tr>
<td>90000 – 98000</td>
<td>Office notes or detailed description of services</td>
</tr>
</tbody>
</table>

Pharmaceuticals | Medical Record Type
--- | ---
J3490, J8999, J9999 | Name of drug, physician’s orders, NDC code
Synvisc | Name of drug, physician’s orders, NDC code
IV therapy (including home infusion) | Name of drug, physician’s orders, NDC code, treatment plan (if applicable)
Remicade, Synagis | Name of drug, physician’s orders, NDC code, patient’s weight at time of drug administration

Miscellaneous HCPCS | Medical Record Type
--- | ---
E1399, L0099 - L9900 | Description, order invoice (if applicable)
Other misc. HCPCS codes | Lab report, test results or documentation of Medical Necessity, as appropriate

Other | Medical Record Type
--- | ---
DME HCPCS codes | Documentation of Medical Necessity and physician’s orders

Additional Medical Records Anthem Also May Request

Some situations may require additional medical records. Although these situations may not have specific rules and guidelines, Anthem will make every attempt to make these requests explicit and limited to the minimal requests necessary to render a decision. Examples include, but aren’t limited to, the following:

- Medical records requested by a member’s Blue Cross and/or Blue Shield home plan (National Accounts)
- Federal Employee Plan requirements
- Review and investigation of claims (e.g., pre-existing conditions, lifetime benefit exclusions)
- Medical review and evaluation
- Requests for retro authorizations
- Medical management review and evaluation
- Underwriting review and evaluation
- Adjustments
- Appeals
- Quality management (quality of care concerns)
- Records documenting prolonged services
Claim Action Request Procedures

When to Submit a Claim Action Request

*Please submit claim action requests only when the claim has been processed through finalization, and the claim appears as paid or denied on your EOB/RA or when you have received a letter requesting additional information before the claim can be processed.* A claim action request may be needed as the result of a processing error, correcting claim information, missing or incomplete information, etc.

Anthem provides the claim action request process as an informal way for providers to request reconsideration of a claim determination made by Anthem. The claim action request process isn’t the same as an appeal. However, it’s often the quickest way to process a claim reconsideration.

**Please note:** Please direct claim status inquiries to our interactive voice response (“IVR”) system, to our website at anthem.com (see the Provider Portal Connectivity Options section for more details) or to provider customer service (see the Telephone/Address Directory section for the phone numbers). Sending claim status inquiries via a Claim Action Request Form will delay the response to your inquiry.

How to Submit a Claim Action Request

- Requests must be submitted on a Claim Action Request Form, completed entirely.
- Submit only one claim on each Claim Action Request Form.
- Include the corresponding claim control number for each action request.
- Specify in detail the issue and the action requested.
- Attach all documentation to support the action request, i.e., medical records, letter of appeal, corrected claim form, etc.

How to Obtain a Claim Action Request

This form is available in electronic format for typing your information. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Answers@Anthem tab, select the link titled “Download Commonly Requested Forms”, then “Claim Action Request Form”.

Where to Send Completed Claim Action Request

For Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):

Anthem Blue Cross and Blue Shield
P.O. Box 5747
Denver, CO 80217-5747
For Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):

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

Who to Contact with Questions about Claim Action Requests

Please call provider customer service (see the Alpha Prefix Reference List for the appropriate phone number).

Reimbursement Policies/Professional Reimbursement

Professional Reimbursement Policies

Our Reimbursement Policies are located on our secure provider portal, ProviderAccess. Go to anthem.com and click the Providers link in the upper left corner. Select Nevada from the state drop-down box, and Enter. From the ProviderAccess Login tout (blue box on the left side of the page), select Medical from the drop down list and click on the login button. Enter your user name and password. Once logged into ProviderAccess, from the Overview tab, under the Policies and Procedures section, select the link titled “View Reimbursement Policies”. From the Anthem’s West Clinical Policies – Overview page, select Continue. Select All Clinical Policies tab. Select the Reimbursement Policies link, then select the policy you would like to view.

If you are not currently a registered user of our secure provider portal, see the ProviderAccess section of this Manual.

Claims Editing Software Programs

Services must be reported in accordance with the reporting guidelines and instructions contained in the American Medical Association (“AMA”) CPT Manual, “CPT® Assistant,” and HCPCS publications.” Providers are responsible for accurately reporting the medical, surgical, diagnostic, and therapeutic services rendered to a member with the correct CPT and/or HCPCS codes, and for appending the applicable modifiers, when appropriate.
Effective with claims processed on or after November 14, 2009, Anthem is utilizing a claims editing software product from McKesson, Inc., called ClaimsXten®. ClaimsXten includes the McKesson incidental, mutually exclusive and unbundled/rebundle edits as well as other editing rules including National Correct Coding Initiative (“NCCI”) edits, CMS Medically Unlikely Edits (“MUEs”) and other frequency edits. It also provides the editing tools to incorporate the administration of many of our reimbursement policies.

Anthem will be upgrading our current ClaimsXten version 4.1 claims editing software package to ClaimsXten version 4.4. Enhancements to our current system are necessary in order to meet the requirements of ICD-10 reporting. This upgrade, scheduled for December 8, 2012, will also enable us to adjust some current system limitations affecting claims processing and add additional edits to support some new reimbursement policies. Please refer to the Reimbursement Policy Change Notification dated August 31, 2012 for more detailed information about this update.

ClaimsXten will continue to be updated on a quarterly basis. In addition to adding new CPT codes, HCPCS codes, and NCCI edits, McKesson continues to add and revise content based on ongoing review of the entire knowledge base. This continuous process helps to ensure that the clinical content used in ClaimsXten is clinically appropriate and withstands the scrutiny of both payers and providers. The quarterly updates will be incorporated without specific notification.

ClaimsXten is used to evaluate the accuracy of medical claims and their adherence to accepted CPT/HCPCS coding practices and it allows us to monitor the increasingly complex developments in medical technology and correct procedure coding used to process physician payments. American Medical Association Complete Procedural Terminology (CPT®), CPT Assistant, coding guidelines developed from national specialty societies, CMS, NCCI, Healthcare Common Procedure Coding System (HCPCS®), American Society of Anesthesiology (“ASA”), and other standard-setting organizations for claims billing procedures are considered in developing Anthem’s coding and reimbursement edits and policies.

Anthem has made customizations to the ClaimsXten software to support our reimbursement policies. (The list of reimbursement policies with Customized Edits and the Reimbursement Policies are posted on our provider portal, ProviderAccess. If you are not currently registered, see the Provider Portal Connectivity section for further details).

Please see Reimbursement Policy: Claims Editing Overview for more information on individual edits.

Some of the edits ClaimsXten performs are listed below:

- **Procedure unbundling** occurs when two (2) or more procedures are used to describe a service when a single, more comprehensive procedure exists that more accurately describes the complete service performed by a provider. In this
instance, the two (2) codes may be replaced with the more appropriate code by our bundling system.

- **An incidental procedure** is performed at the same time as a more complex primary procedure. The incidental procedure doesn’t require significant additional physician resources and/or is clinically integral to the performance of the primary procedure.

- **Mutually exclusive procedures** are two (2) or more procedures usually not performed during the same patient encounter on the same date of service. Mutually exclusive rules may also govern different procedure code descriptions for the same type of procedure for which the physician should be submitting only one (1) procedure.

- **National Correct Coding Initiative (“NCCI” or “CCI”) edits** developed by CMS will be applied effective on or after November 14, 2009 with the implementation of ClaimsXten. These edits will be applied to code pairs after the standard ClaimsXten incidental, mutually exclusive and/or re-bundled edits have been applied and will follow the NCCI modifier allowed designations.
  
  - Effective with the upgrade to ClaimsXten v4.4, Anthem has adopted the CMS code pair superscript modifier override guidelines for Non Site Specific Modifiers: 25, 58, 59, 78, 79 and 91. To override an edit, when applicable (superscript = 1) by NCCI guidelines, the over-riding modifier must be appended to the denied or "column 2" code).

- **Duplicate procedure** editing involves duplicate procedures submitted with the same date of service. Duplicate procedures include the following:
  
  - When the description of the procedure contains the word “bilateral,” the procedure may be performed only once on a single date of service.
  
  - When the description of a procedure code contains the phrase “unilateral/bilateral,” the procedure may be performed only once on a single date of service.
  
  - When the description of the procedure specifies “unilateral” and there is another procedure whose description specifies “bilateral” performance of the same procedure, the unilateral procedure may not be submitted more than once on a single date of service.
  
  - When the description of one procedure specifies a “single” procedure and the description of a second procedure specifies “multiple” procedures, the single procedure may not be submitted more than once on a single date of service.

- The **global duplicate value** is the total number of times it’s clinically possible or Medically Necessary to perform a given procedure on a single date of service across all anatomic sites.

- **Age edits** occur when the provider assigns an age-specific procedure or diagnosis code to a patient whose age is outside the designated age range.
• **Gender edits** occur when the provider assigns a gender-specific procedure or diagnosis code to a patient of the opposite sex.

• **Frequency edits** occur when a procedure is billed more often than would be expected. Frequency edits occur when:
  - Base procedure codes are billed with a quantity greater than one on a single date of service.
  - Procedures whose description includes a numeric definition or the term “single,” “one or more”, bilateral or “multiple” are billed with a quantity greater than one (1) on a single date of service.
  - In the case of procedures that are allowed with more than one (1) unit per date of service, the line item that exceeds the maximum allowed per date of service will be denied and replaced with a new corrected line item showing the appropriate number of units.
  - For more information on frequency edits refer to Reimbursement Policy: Frequency Editing

• **Pap Smear lab codes with E/M codes** are not eligible for separate reimbursement. In most cases when a family physician, internist, obstetrician/gynecologist or other qualified provider submits a cytopatology/Pap smear code they are not the physicians conducting the screening and/or interpreting the Pap smear. They are the providers who obtained the specimen. The pathologist preparing and interpreting the cytopathology/Pap smear must bill for this service separately.
  - Therefore, Anthem Bundles 88141-88155, 88164-88167, 88174-88175 Pap smear (Papanicolaou test or cytopathology smear) as mutually exclusive with E/M codes.

• **History Editing Occurs when a** previously submitted historical claim that is related to current claim submission is identified. This identification/edit may result in adjustments to claims previously processed. An example of such a historical auditing action would occur when an E/M visit is submitted on one (1) claim and then a surgery for the same service date is submitted on a different claim. If a determination that the E/M visit paid in history is included in the allowable for the surgery, an adjustment of the E/M claim will be necessary, this may result in an overpayment recovery.
  - History editing capability enables us to auto-adjudicate some of our reimbursement policies including, but not limited to; global surgery, multiple visits per day, pre/post-operative visits, new patient visits, frequency rules, incidental, mutually exclusive and rebundle edits and maternity services.
- This edit was effective with claims processed on and after the ClaimsXten implementation on November 14, 2009.

- **Bundled Services and Supplies edits** occur when the editing system identifies certain services and supplies that are considered to be an integral component of the overall medical management service and care of the member and are not reimbursed separately.
  - These services and/or supplies may be reported with another service or as a stand alone service.
  - When reported with another service, modifier 59 will *not* override most of the denials for the bundled services and/or supply. Please refer to Reimbursement Policy: Modifier 59.
  - Editing for this rule is based on CMS, McKesson and Anthem sourcing.
  - Please refer to Reimbursement Policies: Bundled Services and Supplies, Injection and Infusion Administration and Bundled Services and Supplies for Polysomnography and Other Sleep Studies/Tests

- **Place of Service edits** identify the reporting of an inappropriate place of service for a particular procedure, either due to the descriptive verbiage of the code, or due to published CPT coding guidelines which indicate that a specific procedure is not intended to be reported in a certain setting. Please refer to reimbursement policy: Place of Service.

- **Multiple Surgery and Multiple Endoscopy Rule** calculations will be based on the highest RVU rather than the highest allowed amount effective January 1, 2013 after the ClaimsXten version 4.4 upgrade. New Multiple Endoscopy reductions, less than the standard 50% reduction for subsequent procedures and approximating the CMS logic range from 25 to 35 percent depending on the base code family will also be implemented effective January 1, 2013. Please refer to reimbursement policy: Multiple and Bilateral Services.

- **Multiple Diagnostic Imaging** reimbursement rules will be applied to the technical component of radiologic procedures that have a Multiple Procedure Indicator (MPI) of four (4) in the multiple procedure column of the CMS NPFSRVF with the implementation of the ClaimsXten 4.4 upgrade. Please refer to reimbursement policy: Multiple Diagnostic Imaging Reimbursement.

- **Durable Medical Equipment (DME)** edits are being added with the ClaimsXten 4.4 upgrade. Please see the new DME reimbursement policy pertaining to the purchase and rental of DME equipment as well as additional billing guidelines required in order for a DME item to be eligible for reimbursement.

*ClaimsXten®* is a registered trademark of McKesson HBOC.
Clear Claim Connection™

Clear Claim Connection (“CCC”) is an online tool available through Anthem’s provider portal, ProviderAccess, intended to be a tool for evaluating clinical coding information. CCC will provide information according to the claim editing system logic on the date of the provider’s inquiry, and allows providers to view clinically-based information along with documented source information for approximately two million edits. CCC is not a guarantee of member eligibility or claim payment, and is not date-sensitive for the claim date of service. The RVUs in CCC are the current RVUs which may be different from the RVUs on the the date of service of a previously processed claim. While most of our reimbursement policies are loaded in CCC some are not.

Sources referenced for the CCC online tool include: CPT, CPT Assistant, CPT Coding Symposium, Specialty Society Coding Guidelines and Medicare Guidelines. Not all National Accounts, FEP or Medicare Advantage products utilize the claim editing system logic used in CCC, and not all procedure modifiers impact the pricing or processing of procedures (based on Anthem policy).

To access the CCC online tool, login to our secure provider portal, ProviderAccess. Go to anthem.com and click the Providers link in the upper left corner. Select Nevada from the state drop-down box, and Enter. From the ProviderAccess Login tout (blue box on the left side of the page), select Medical from the drop down list and click on the login button. Enter your user name and password. Once logged in, from the Claims tab, select the Clear Claim Connection link.

Clear Claim ConnectionTM is a trademark of McKesson.

Modifiers

In certain circumstances, it is appropriate to use modifiers to report services that warrant reimbursement separately from what would usually be expected. The use of the modifiers, listed below should be reserved for special circumstances prompted by an individual situation involving a specific patient. The use of these modifiers should not be routine. More information about using modifier 25 and 59 and exceptions to recognition of modifiers 25 and 59 processing guidelines in addition to their separate policies, is available on our secure provider portal, ProviderAccess. Go to anthem.com and click the Providers link in the upper left corner. Select Nevada from the state drop-down box, and Enter. From the ProviderAccess Login tout to the (blue box on the left side of the page), select Medical from the drop down list and click on the login button. Enter your user name and password. Once logged in, from the Overview tab, under the Policies and Procedures section, select the link titled “Modifier 25 & 59 Rules”.

- Modifier 25 is used to indicate that on the day a procedure or preventive exam was performed, the patient’s condition required a significant, separately identifiable E/M service beyond the usual care associated with the procedure or preventive exam. Without the modifier-25 designation, the E/M code is bundled
into the procedure, or preventive exam. Only append modifier 25 to E/M codes 99201-99499.

- **Routine use of modifier 25 to avoid bundling edits is inappropriate.**
- **Only use modifier 25 for unique situations as indicated above.**
- If modifier 25 is appended to inappropriate codes, it will be disregarded. Or denied as inappropriate use of the modifier.
- When more than one problem oriented E/M service is performed on the same day, only the most clinically intense E/M service should be reported. Effective for claims processed on or after the ClaimsXten 4.4 upgrade scheduled for December 8, 2012, modifier 25 will not override the edit for two separate problem oriented E/M services reported on the same date of service by the same provider (or more than one provider of the same specialty in the same provider group).
- For more information on Modifier 25 please refer to Reimbursement Policy: Evaluation and Management and related Modifiers 25 and 57.

- **Modifier 57** is used to identify the patient encounter that resulted in the decision to perform surgery. Without the modifier, the E/M code is bundled to the surgical procedure when performed the day of or the day before a major surgical procedure.

- **Modifier 59** is used to identify procedures/services that aren’t normally reported together but are appropriate under the circumstances. This may include a different procedure or surgery, a different site, or a separate incision/excision, lesion or patient encounter. Without the modifier 59 designation, bundling may occur. Effective on November 14, 2009, ClaimsXten implemented NCCI edits. Effective May 23, 2010, with the 2nd quarter ClaimsXten update, we are following most “modifier allowed” CMS logic as well. If the “Modifier Allowed” designation for the code pair is zero; modifiers (such as modifier 59) will not override the edit (Anthem has made customizations to some code pairs and will not allow modifier 59 to override these customizations.)

  - **Only append modifier 59 to procedures or surgeries.**
  - Modifier 59 is not appropriate for supplies, DME codes, drugs or “J” codes or E/M codes.
  - If modifier 59 is appended to inappropriate codes, it will be disregarded or denied as inappropriate use of the modifier.
  - **Routine use of modifier 59 to avoid bundling edits is inappropriate. Only use it in unique situations as indicated above.**
  - For more information on Modifier 59 please refer to Reimbursement Policy: Modifier 59.
• **Modifier 50** is used to indicate a bilateral procedure. A bilateral procedure is reported on **one line** with the unilateral surgical procedure code, **one unit** of service and **modifier 50**. Bilateral surgeries/procedures are considered one surgery. Effective January 1, 2013, after the ClaimsXten upgrade, Anthem will apply the increased allowance of 150% for bilateral procedures to the RVU for the procedure code prior to the applying the multiple surgery reimbursement rules. This higher RVU is used when ranking multiple procedures based on highest RVU to determine which procedure is the primary service and which is the secondary/subsequent service(s). (Claims are processed based on the RVU for the date of service. Because CMS updates their files on a quarterly basis, the RVU for the date of service may be different than the current RVU seen on Clear Claim Connection.) For additional important information about Modifier 50 processing and modifier 50 assumptions, please refer to Reimbursement Policy: Multiple and Bilateral Surgery.

• **Additional Modifiers** and their effect on claims processing are included in Reimbursement Policy Modifier Rules.

**Resource Based Relative Value Scale**

Anthem’s fee schedule is based on the CMS Resource Based Relative Value Scale ("RBRVS").

The RBRVS is based on the resources a physician typically uses for each procedure and service, from physical, intellectual and emotional effort to overhead and training. The following components are used in computing a fee for a given service:

- Physician work
- Practice expense, including office rent, non-physician salaries, capital equipment costs and **supplies**
- Professional liability (malpractice) expense, including the cost of professional liability insurance

The RBRVS method doesn’t set unit values for anesthesiology and clinical laboratory procedures. In these instances, Anthem uses ASA relative values for anesthesiology and CMS fees for clinical lab.

Throughout this Manual, Anthem’s method of reimbursement will be referred to as the current Anthem fee schedule, which is a combination of the modified RBRVS values, the services not evaluated by RBRVS and the Anthem conversion factor.

**On-call Coverage for Primary Care Physicians**

PCPs are required to provide twenty-four (24) hour coverage, seven (7) days a week, for Anthem members. After-hours coverage may consist of the following:
• A covering physician who is a PCP in the member’s designated PCP’s clinic or medical management group, in which case a referral isn’t necessary

• The covering physician is a Provider with Anthem, and the covering physician’s name is in the Anthem system as an on-call provider for the PCP. When an Anthem member sees an on-call provider, claims are processed at the on-call provider’s contracted rate with Anthem.

Please forward updated on-call information, in writing, to the Provider File Management address listed in the Customer Service and ProviderAccess section of this Manual.

**Facility Reimbursement Policies**

**Changes During Admission**

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

<table>
<thead>
<tr>
<th>CHANGE</th>
<th>EFFECTIVE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member’s Insurance Coverage</td>
<td>Admission</td>
</tr>
<tr>
<td>Facility’s Contracted Rate (other than DRG)</td>
<td>Admission</td>
</tr>
<tr>
<td>DRG Base Rate</td>
<td>Admission</td>
</tr>
<tr>
<td>DRG Grouper</td>
<td>Discharge</td>
</tr>
<tr>
<td>DRG Relative Weight</td>
<td>Discharge</td>
</tr>
</tbody>
</table>

**Implants**

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

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

Anthem shall not process claims submitted as interim bills for services reimbursed under DRG methodology.

Non-Covered Use of Observation Beds

The Covered Individual's medical record documentation for Observation status must indicate the need for Observation stating the specific problem, treatment and/or frequency of the skilled service and requires a written order by the physician clearly documented in the medical record indicating “Admit to Observation”.

The following situations are considered inappropriate use of observation care:

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

Services related to observation beds for the above situations are not reimbursable.

Observation does not apply to clinics, physician offices, urgent care centers, mental health or substance abuse care and cannot be used for a planned or elective admission.

Anthem shall reimburse the Facility only for Covered Services provided to a Covered Individual in an observation/treatment room as specified in the Facility Plan Compensation Schedule or Contract.

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.
Portable Charges

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

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.

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.

Test or Procedures Prior to Admission(s)

As applicable to your contract, 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 member prior to Facility rendering services to members. 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 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, 93543, 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 member’s admission as an inpatient.

**Time Calculation**

- Operating Room ("OR") – OR time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the OR 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, IV sedation etc., 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 ("PACU") record.
- Post Recovery Room – Time Charges should be calculated from the time the patient leaves the recovery room until discharge.

**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 for batteries, covers, film, anti-fogger solution, tapes etc, are not separately reimbursable.

**Coordination of Benefits/Subrogation**

Coordination of benefits ("COB") refers to the process for members receiving full benefits while preventing double payment for services when a member has coverage from two or more sources. The member’s contract outlines which entity has primary responsibility for payment and which entity has secondary responsibility for payment.
Providers and Facilities shall establish procedures for identifying members who have work-related injuries or illnesses or who have other coverage (including auto insurance), that may be coordinated with Anthem coverage. Providers shall use their best efforts to notify Anthem whenever they have reason to believe a member may be entitled to coverage under any other insurance plan, including Medicare, and shall assist Anthem in obtaining COB information when a member holds such other coverage.

Providers and Facilities agree to make their best effort to identify and notify Anthem of any facts that may be related to auto, workers’ compensation, or third-party injury or illness, and to execute and provide documents that may reasonably be required or appropriate for the purpose of pursuing reimbursement or payment from other payers.

This section shall not be construed to require Provider or Facility to waive Cost Shares in violation of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation.

Anthem adjudicates COB claims according to the following guidelines:

- When Anthem is the primary carrier, standard Anthem reimbursement, along with applicable copayments, coinsurance and deductibles, is considered payment in full from Anthem.

- If Medicare is the primary payer, and member has full basic secondary coverage through Anthem (non-Medicare Supplement), Anthem will use the Medicare allowed amount or the limiting amount (if the provider didn’t accept Medicare assignment) to determine a secondary payment.

- For PPO and Indemnity claims when Anthem is the secondary carrier and the primary carrier isn’t Medicare, the primary carrier’s allowance will be used to determine a secondary payment.

- For HMO claims when HMO Nevada is the secondary carrier and:
  - HMO Nevada’s reimbursement is non-capitated, i.e., some form of fee-for-service: When the primary carrier is not Medicare, the primary carrier’s allowance will be used to determine a secondary payment.
  - Medicare is the primary payer: HMO Nevada will use the Medicare allowed amount or the limiting amount (if the provider did not accept Medicare assignment) to determine a secondary payment.

- At no time will Anthem pay more as the secondary carrier than it would have paid had it been the primary carrier.

Members with Individual Plan Coverage

Benefit payments for Anthem members with Individual coverage cannot be coordinated with another commercial health insurance, auto medical payments or third-party liability coverage. However, benefits may be coordinated with workers’ compensation or
Medicare. Before sending Anthem a refund due to duplicate claims payment, please verify that the refund being submitted is for a member with Group – not Individual – coverage.

**Coordination of Benefits for BlueCard®**

If, after calling 800-676-BLUE or through other means you discover that a member’s insurance plan contains a COB provision, and if any Blue Cross and/or Blue Shield plan is the primary payer, please submit the claim(s) along with information about COB to Anthem. If COB information isn’t included with the claim, the member’s plan or the insurance carrier will have to investigate the claim, which will delay claim processing.

**Coordination of Benefits for the FEP**

In certain circumstances when FEP is the secondary payer and there is no adverse effect on the Covered Individual, we may take advantage of any provider discount arrangements the primary payer 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.

**Eligibility and Payment**

A guarantee of eligibility is not a guarantee of payment.

**Copayments/Cost Shares**

Providers should only collect copayments/Cost Shares from members at the time services are rendered. Please refer to the member’s health plan ID card for copayment/Cost Share information.

**Office Visit Copayments**

An office copayment is required for most office visits for which a provider’s office ordinarily generates a charge, including blood pressure checks, regularly scheduled injections and educational sessions with a nutritionist, physical therapist, etc. If a charge isn’t generated for a visit, the provider doesn’t collect a copayment.

**For HMO Nevada members only:** Non-surgical diagnostic procedures for which there are no other associated office visit charges are the only services for which a provider doesn’t collect an office visit copayment from an HMO Nevada member. Such services include lab work, X-rays, mammograms, audiograms, EKGs, etc. Immunizations and flu shots do not require a copayment if no other office visit charge is associated with these procedures.
Emergency/Urgent Care Copayment

The emergency care copayment is collected by the emergency room at an acute care hospital.

The urgent care copayment is collected by the PCP’s office when:

- The office must disrupt its schedule to see an Anthem member on an urgent care basis during the day; or
- The physician sees the member after hours or during weekend hours when no facility fee is charged.

The urgent care copayment is collected when a member is seen at an urgent care center. These amounts are listed on the member’s health plan ID card. For HMO Nevada members only, the emergency and urgent care copayments most often are the same amount, although in some cases, the copayment amounts will be different.

Inpatient Hospital Copayment

The inpatient hospital copayment is paid to hospitals for inpatient admissions. Payment arrangements can be made between the hospital and the member before an inpatient hospital admission.

Urgent Care Services

Valid procedure codes must be used when medical services are rendered in the office rather than sending the member to the emergency room in an urgent or emergency situation outside normal office hours.

After-hours care/office services code 99050 may be allowed in addition to the basic service when care is requested outside a provider’s normal or published office hours, such as between 10 p.m. and 8 a.m., or services are requested when a provider’s office is closed on weekends and holidays.

Code 99051 may be allowed in addition to the basic service when Service(s) are provided in the office during regularly scheduled evening, weekend, or holiday office hours.

See Reimbursement Policy Urgent Care – Coding and Bundled Supplies for more information.

The applicable deductible, coinsurance and/or co-payment requirements for urgent care services remain in place, and Anthem members are responsible for paying those cost-sharing amounts.
Emergency Services

Benefits for routine or preventive care services provided in the emergency department are not within the meaning of emergency services.

The applicable deductible, coinsurance and/or co-payment requirements for emergency services remain in place, and Anthem members are responsible for paying those cost-sharing amounts.

Preventive Care Services

Preventive care services are covered based on the Nevada state mandates and include:

- Cervical cancer vaccines (HPV)
- Prostate Cancer screening
- Cytologic screening (pap smear)
- Mammograms
- Gynecological or obstetrical services
- Colorectal cancer screening

Changes in Preventive Care Benefits Due to Health Care Reform

The new health care reform law (the Patient Protection and Affordable Care Act or “PPACA”) will require Anthem Blue Cross and Blue Shield (Anthem) to cover additional preventive care services and eliminate member cost-sharing (copayments, deductibles, or coinsurance) for certain in-network preventive care services. Cost-sharing requirements for preventive care services rendered out-of-network will continue to apply as they do today.

In general, changes in preventive care benefits for group health plans and group insurance policies administered or issued by Anthem will be effective on the first day of the plan year or the group policy’s renewal date on or after September 23, 2010. The changes will be effective for individual policies on the first policy year date on or after September 23, 2010, which in almost all cases will be January 1, 2011. There are some exceptions to these dates, and not all plans will be subject to the new preventive care coverage requirements, so providers should continue to verify eligibility and benefits through their normal business processes.

Health Care Reform Impacts Member Policies Differently

The newly enacted health care reform legislation will be implemented in phases until it is fully effective in 2014. During the implementation process, we will strive to give you important information and clarify how these changes will impact your day to day business with Anthem Blue Cross and Blue Shield (Anthem).
It is important to understand that not all member plans will be required to meet all the coverage requirements of the new health care reform law. Policies that are “grandfathered” are exempt from some of the requirements of health care reform. Conversely, certain changes must be made to all plans, whether they are grandfathered or not.

Because the health care reform provisions are implemented based on the plan or policy issue date, the date that provisions are effective will vary from member to member. The effective date will also be affected by the policy type (group or individual) and other factors. As an example, the provisions that take effect on September 23, 2010 will be implemented for most group policies at the first renewal occurring on or after that date. Individual policies will have effective dates that are based on the policy year date, which is almost always January 1, 2011.

We understand that there may be challenges in understanding when and how provisions apply to specific policies, and we want to help keep your eligibility and benefits process simple. As member coverage is modified to reflect the new benefits associated with health care reform, our systems will be updated to share the most up-to-date benefit information. It is imperative that providers continue verifying eligibility and benefits for your Anthem patients by accessing our secure Provider portal, ProviderAccess, or by contacting Customer Service at the number on the back of the members Health Plan ID card.

You can continue to check for new communications about health care reform at Health Care Reform Notifications and Updates on the provider website. If you have questions about how health care reform will impact you or your patients, you can visit www.healthychat.com to submit these questions. This website is dedicated to helping the public understand the many parts of health care reform.

**Voluntary Refund Procedure**

If the facility or provider discovers that an overpayment has been made and would like to refund the overpaid amount voluntarily, please send the payment, a completed Provider Refund Adjustment Request (“PRAR”) Form, and all supporting documentation to the address listed below.

**Supporting Documentation:**

- EOB, Other Carrier EOB, or EOMB
- Duplicate Payment Information
- Corrected Claims or Billing
Send all payments with a completed PRAR Form and all supporting documentation to:

- For overpayments for Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):
  Overpayment Recovery
  P.O. Box 92420
  Cleveland, OH 44193

- For overpayments Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):
  Central Region - CCOA Lockbox
  P.O. Box 73651
  Cleveland, OH 44193-1177

Note: Please reference the claim number, patient name, member ID#, date of service, billed amount, refund amount, and detailed reason for the refund with all payments.

Provider Refund Adjustment Request (PRAR) Form

The PRAR Form can be downloaded and/or printed from anthem.com. Select Providers, choose Nevada from the state drop-down box and click Enter. Click Download Commonly Requested Forms, and then click Provider Refund Adjustment Request Form. The form is a Word document that can be completed electronically.

Overpayment Recovery Procedure

Anthem seeks recovery of all excess claim payments from the payee to whom the benefit check is made payable.

The procedure for overpayment recovery for Providers and Facilities involves the following notifications to physicians, hospitals, facilities and other health care professionals:

- **Day 1:** Anthem identifies overpayment.
- **Day 3:** A letter is sent to the provider requesting overpayment.

If the facility or provider believes the overpayment was created in error, it should contact Anthem in writing. For a claims re-evaluation, send your correspondence to the address indicated on the overpayment notification.

Send all payments with a copy of the overpayment letter and/or a completed Provider Refund Adjustment Request (PRAR) Form to:
• For overpayments for Local Plan members and BlueCard members (all alpha prefixes other than R + 8 numerics):
  Overpayment Recovery
  P.O. Box 92420
  Cleveland, OH 44193

• For overpayments Federal Employee Program (FEP) members (alpha prefix R + 8 numerics):
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  Note: Please reference the claim number, patient name, and member ID# with all payments. Make the payment amount equal to the amount requested on the overpayment letter if possible.

If Anthem doesn’t hear from the facility or receive payment within 30 days, the following action is taken:

  Day 30: A second letter is sent to the provider. This is a final request for payment. The letter indicates that if Anthem doesn’t receive payment within 15 days, then the overpayment amount “recovery” is taken out of future claims payments.

  Day 45: If Anthem doesn’t receive payment, the overpayment amount is deducted from claims payments.

  Day 60: When Anthem determines that recovery isn’t feasible, a third letter is sent to the provider.

  Day 90: If Anthem doesn’t receive payment, a fourth letter is sent to the provider.

  Day 110: If Anthem doesn’t receive a check for the overpayment, the overpayment is referred to a collection service.

Important Information about the Federal Employees Health Benefits Program

The following information applies to members who:

• Aren’t covered by either Medicare Part A (hospital insurance) or Part B (medical insurance), or both.

• Are enrolled in the Blue Cross and/or Blue Shield plan as an annuitant, or as a former spouse or family member covered by the family enrollment of an annuitant or former spouse.

• Aren’t employed in a position that confers Federal Employees Health Benefit Program coverage.
If the member isn’t covered by Medicare Part A, is age 65 or older and receives care in a Medicare-participating hospital, the law (5 U.S.C. 8904[b]) requires the Blue Cross and/or Blue Shield plan to base payment on an amount equivalent to the amount Medicare would have allowed if the member had Medicare Part A. This amount is called the equivalent Medicare amount. After the Blue Cross and/or Blue Shield plan pays, the law prohibits the hospital from charging the member more for covered services than any deductibles, coinsurance or copayment owed by the member under the Blue Cross and/or Blue Shield plan. Any coinsurance the member owes will be based on the equivalent Medicare amount, not the actual charge.

Preventable Adverse Events (“PAEs”) Policy – Acute Care General Hospitals

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 not bill, nor seek to collect from, nor accept any payment from Anthem or the covered individual for such events. If acute care general hospital receives any payment from Anthem or the covered individual for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt. Further, acute care general hospital shall cooperate with Anthem, to the extent reasonable, in any Anthem initiative designed to help analyze or reduce such PAEs.

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

<table>
<thead>
<tr>
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<th>Definition / Details</th>
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<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>
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<td>2. Surgery Performed on the Wrong Patient</td>
<td>Any surgery on a patient that is not consistent with the documented informed consent for that patient. Surgery includes endoscopies and other invasive procedures.</td>
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### 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.

### PAE Policy – Providers and Facilities (excluding Acute Care General Hospitals)

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

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

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

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

Provider and Facility agree that Anthem, Plans or its designees may use, publish, disclose, and display information related to demographics, credentialing, affiliations, and transparency initiatives, such as but not limited to Anthem Care Comparison, relating to Provider or Facility for commercially reasonable general business purposes.

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**Medical Policies and Clinical Utilization Management ("UM") Guidelines**

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

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

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled "Medical Policies, Clinical UM Guideline, and Pre-Cert Requirements". (Please note Medical Policies are now available for Local Plan members as well as BlueCard/Out-of-are members.)

- **For Clinical UM Guidelines for Local Plan members:**
  Follow the information for Medical Policies listed above. From the Medical Policies and Clinical UM Guidelines page for Local Plan members, at the bottom of the page, before the “continue” button, is a link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Nevada”. Please note all of our Clinical UM Guidelines for our entire organization are
Medical Policy Formation

The Medical Policy & Technology Assessment Committee ("MPTAC") is the authorizing body for Anthem medical policy and clinical UM guidelines which serve as a basis for coverage decisions. The Office of Medical Policy & Technology Assessment ("OMPTA") develops medical policy for the company. The principal component of the process is the review for development of Medical Necessity and investigational position statements for certain new medical technologies and/or procedures or for new uses of existing technologies and/or procedures. The technologies include devices, biologics and specialty pharmaceuticals, and behavioral health services.

Medical policies are intended to reflect the current scientific data and clinical thinking. While medical policy will set forth position statements for policy development and updating regarding the Medical Necessity of individual technologies, etc., Federal and State law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining eligibility for coverage.

The MPTAC is a multi-disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership includes external physicians in clinical practices and participating in networks; external physicians in academic practices and participating in networks; and internal medical directors. Non-voting members include internal legal counsel.

The committee meets at least three times per year. Agenda topics are identified, researched, updated, collated and distributed to the committee. Input from the medical community is solicited and utilized in developing and updating policies. In addition, agenda items are identified from, but not limited to: clinical literature, medical operations associates, medical directors, claims operations, appeals, technology vendors, and other technology assessment entities. Decisions are made by a majority vote of the MPTAC voting members present. Majority representation of the voting committee members must be present to constitute a quorum. MPTAC may designate subcommittees for certain specialty topics, such as by way of example only, hematology/oncology. The subcommittees may include external physicians that are not members of MPTAC, but are in clinical or academic practices and are participating in networks. The subcommittees shall make recommendations to MPTAC on topics assigned to them by MPTAC.

MPTAC voting members and subcommittee members are required to disclose any potential conflicts of interest. In the event that a MPTAC voting member or
subcommittee member discloses a conflict of interest, the associated member will not participate in the vote specific to the proposed relevant medical policy.

To reach decisions regarding the Medical Necessity or investigational status of new or existing technologies and/or procedures, the MPTAC (and its applicable subcommittees) relies on:

- the technology/procedure having final approval from the appropriate regulatory body;
- the technology/procedure being supported by scientific evidence permitting conclusions regarding the effect of the technology on health outcomes;
- the technology/procedure improving net health outcomes;
- the technology/procedure being as beneficial as established alternatives;
- the technology/procedure outcomes/improvements being attainable outside the controlled setting (in practice).

In evaluating the Medical Necessity or investigational status of new or existing technologies and/or procedures the committee(s) may include, but not limit their consideration, to the following additional information:

- electronic literature searches, which are conducted and collated results are provided to the committee members;
- independent technology evaluation programs and materials published by professional associations; such as:
  - Blue Cross Blue Shield Association (BCBSA);
  - technology assessment entities;
  - appropriate government regulatory bodies; and
  - various medical specialty societies and associations.

The committee(s) may also consider the technology/procedure being reviewed as a standard of care in the medical community with supporting documentation.

Additionally, for topics deemed to represent a significant change or as otherwise required by law or accreditation, the medical policy team seeks additional input from selected experienced clinicians. This process allows MPTAC access to the expertise of a wide variety of specialists and subspecialists from across the United States. These individuals are board certified providers who are identified either with the assistance of an appropriate professional medical specialty society, by activity in a participating academic medical center or by participation in a corporate affiliated network. While the various professional medical societies may collaborate in this process through the provision of appropriate reviewers, the input received represents NEITHER an endorsement by the specialty society NOR an official position of the specialty society. MPTAC uses this information in the context of all other information presented from various sources.
A medical policy may be developed and approved between scheduled MPTAC meetings, if in the opinion of the Vice President of OMPTA or designee, there is an urgent need to establish a new medical policy, or revise an existing policy, prior to the next scheduled meeting of MPTAC. The research associates of OMPTA will develop the draft medical policy and request input from appropriate consultant providers, and if applicable, the relevant subcommittee. An ad-hoc interim medical policy meeting or vote is scheduled to review and vote on the proposed interim medical policy. Any policy presented on an interim basis (whether approved, modified or rejected) will be presented for full review and discussion at the next scheduled MPTAC meeting.

In the absence of specific medical policy, case-by-case individual review is undertaken. A physician designated by the Anthem, will review the request using the technology assessment criteria and appropriate standards that may include, but are not limited to, any of the following: peer-reviewed literature, other organizations’ technology evaluations including the BCBSA, Agency for Health Research and Quality (“AHRQ”), various medical specialty societies’ guidelines and assessments and the clinician’s professional judgment. Refer to the following policy for details: ADMIN.00006 Review of Services for Benefit Determinations in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management (UM) Guideline.

All existing medical policies and clinical UM guidelines are reviewed at least annually to determine continued applicability and appropriateness and to determine whether there is a need for revision, updated citations, etc. and are re-approved through MPTAC.

Medical policy position statements of MPTAC are also communicated throughout Anthem for inclusion in the benefit package and for implementation of the supporting processes. These communication processes include:

- attendance of key staff at MPTAC meetings;
- teleconferences with and written documentation to medical operations associates, medical directors, claims and network services associates;
- provision of MPTAC meeting minutes and other relevant documentation to Anthem leadership.

Medical policy decisions affecting our members are reported by our health plans to and reviewed for input by the appropriate physician quality committees, which have the responsibility for reviewing MPTAC activities.

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

Medical policy and clinical UM guidelines differ in the type of determination being made. In general, medical policy addresses the Medical Necessity of new technology and new applications of existing technology while clinical UM guidelines focus on detailed selection criteria, goal length of stay (GLOS), or the place of service for generally accepted technologies or services.
All medical policies and clinical UM guidelines are publicly available on anthem.com. This provides greater transparency for Providers and Facilities, Covered Individuals and the public in general.

Utilization Management

Utilization Management ("UM") Program

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

Telephonic Preservice Review & Continued Stay Review

A. Provider shall ensure that non-emergency admissions and certain outpatient procedures as specified by Plan are preauthorized. 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. Provider or Facility shall ensure that admissions that result from Emergency Services are authorized within twenty-four (24) hours of the first business day following admission.

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

C. Provider or Facility shall comply with all requests for medical information for continued stay review required to complete Plan’s review and discharge planning coordination. In order to facilitate the review process, Provider or Facility 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, Facility agrees to provide to Anthem the total current Facility Charges for a Covered Individual. This information will be provided by Facility to Anthem at no charge to Anthem.

E. Anthem specific pre-authorization requirements may be confirmed on the Anthem web site or by contacting customer service.
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 Continued Stay 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 continued stay 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 Neo-natal Intensive Care Unit (“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 Health 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

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

Continuity of Care Guidelines

Anthem uses continuity of care guidelines when changes occur in the Provider network, as well as for new Covered Individuals and Covered Individuals with special needs and circumstances. The purpose of the guidelines is to help ensure the medical and psychosocial needs of the Covered Individual are met with minimal disruption to all involved parties. Continuity of care for Covered Individuals to continue access to the Provider through the current period of active treatment, or for up to 90 calendar days (whichever is less).

Elements of Transition

Early notification: Typically, a patient who is changing health plans involuntarily will experience a time delay between the notice of change and the effective date with the new Anthem plan. As soon as possible, the patient should advise the current physician practice about the change, and Anthem will coordinate with the previous health plan’s physician advisor and the nurse care managers to facilitate a smooth transition. During this transition period, Anthem will make the following available:

- A written description of its process for facilitating continuity of care
- A written description of its review process for requests to continue services with an existing provider not contracted with Anthem

Identifying patients with special needs and circumstances: Current physicians are expected to identify patients who have unique needs and initiate a process to facilitate their transition to a new Provider, or to continue to provide the care when the Provider is terminating the Provider’s contract with Anthem and will no longer be a contracted Anthem Provider.

- If requested by the patient and to ease referral and physician selection, Anthem will provide a list of available participating Providers and information for contacting those Providers. A nurse care manager will be available to facilitate and verify continuity of care has occurred.
- If requested by the patient, it’s appropriate for the current physician to suggest a physician to the patient and then to begin communication with that physician.

Transition planning visit: During the period before Anthem coverage is effective, the current physician and patient should schedule a visit to facilitate a smooth transition to
the accepting physician’s practice. An Anthem nurse care manager will be available to help during this transition.

**Transfer of patient information:** The current treating physician should:

- Collect and prepare for the transfer of adequate medical records to inform the accepting physician of the patient’s past medical history, treatment modes, medication history, pertinent diagnostic measures, current treatment plan, etc.
- Write a letter of referral summarizing pertinent historical and biographical data to facilitate the accepting physician’s development of rapport with the patient and the patient’s family.

The Anthem nurse care manager will be available to facilitate this communication process.

**Introductory visit to the accepting physician:** This may be arranged as soon as is practical after Anthem coverage becomes effective. The current treating physician should make a recommendation to the patient about the timeliness of scheduling the first appointment. The purpose is to begin developing relationships, to ensure pertinent records are available, to transfer prescriptions if necessary and to consider ancillary needs.

**Physician-to-physician consultation:** It may be appropriate for former and accepting physicians to formally consult about a patient’s unique needs.

**Compensation:** Anthem will compensate the physician for covered services provided when Anthem coverage is in effect, in accordance with the physician’s Provider Agreement with Anthem.

**Clinical and operational transition guidelines:** The nurse care manager handles the continuity of care process, which begins with a request from the patient, physician, plan administrator or previous carrier.

- Coordination of care and services, with specific case review, is set up with the previous carrier’s physician advisor 90 days in advance.
- For a patient receiving inpatient care, continued coverage is provided for appropriate follow-up care with the non-plan physician, or with a physician Provider leaving the contracted Anthem Provider network.
- Coordination of care is provided with the previous carrier’s behavioral health/substance abuse network for those patients for whom a course of treatment has been approved.

The following guidelines also apply when a physician is separating from Anthem:

- When a physician voluntarily leaves Anthem, the physician should initiate the transition process.
- When Anthem initiates disaffiliation, Anthem will initiate the transition process.
Anthem will provide benefit level coverage in the following instances, if the care began before the effective date with Anthem and if the care would have been in-network under the previous carrier’s network:

- A pregnant Covered Individual has had her first prenatal visit and/or she is in or beyond the 20th week of pregnancy.
- Elective surgery was approved by the previous carrier’s pre-certification process, and the surgery was scheduled.
- A Covered Individual is receiving major ongoing treatment for an acute condition.
- The previous carrier approved home health care and home IV therapy.
- The previous carrier approved durable medical equipment.
- A Covered Individual is in a rehabilitation program.
- A Covered Individual has a life-threatening condition.
- A Covered Individual has a terminal illness.

Only medical care directly related to the condition for which the transition benefits have been granted will be paid at the in-network level.

When an out-of-network provider is being treated as in-network, the Anthem nurse care manager will work with that provider and Anthem’s provider services department to negotiate case rates.

The nurse care manager will individually manage participants with certain illnesses, injuries, treatments or medical conditions. If necessary, the nurse care manager will develop a transition plan detailing treatment and/or network physicians/clinics.

In all cases, the decisions will be made in the best interest of the patient and the medical care being provided.

The following are examples of situations when Anthem will apply continuity of care guidelines:

**Situation 1: A Covered Individual is currently receiving long-term treatment from an out-of-network provider for a catastrophic illness.**

Anthem’s health case management department staff will identify these cases, and the designated Anthem care manager will manage them. Covered Individuals may continue their care without interruption for the specific condition for which they are being treated. If the provider treating this patient was considered in-network by the previous carrier, in-network coverage will continue until the Covered Individual may be transferred to an Anthem in-network Provider. However, these Covered Individuals will be transferred to an Anthem in-network Provider if and when appropriate. To determine if benefits will be
paid at the in- or out-of-network level, the assigned care manager will review each case individually.

**Situation 2: A Covered Individual is currently receiving treatment from an out-of-network provider (rehab, follow-up care, etc.) for a short-term illness.**

If the previous carrier considered these services in-network, Anthem will also consider the services in-network if they can be completed one month after Anthem coverage becomes effective. If services will not be completed one month after the Anthem effective date, the nurse care manager will review the case and make a determination. The care manager works jointly with the physician and the Covered Individual to make the best decision for the Covered Individual. If the Covered Individual chooses to remain with the out-of-network provider, the Covered Individual will receive no benefits, including point-of-service benefits, if applicable.

**Situation 3: A Covered Individual enrolled with Anthem is not utilizing in-network Providers.**

Anthem’s customer service will help these Covered Individuals select a physician and follow Anthem’s guidelines to obtain benefits. If continuity of care is needed, the case will be referred to a care manager. If a Covered Individual chooses to use out-of-network providers and not follow the guidelines as detailed in the Covered Individual’s certificate, the Covered Individual will not receive in-network benefits.

**Situation 4: A Covered Individual is currently receiving maternity care and is transferring to Anthem.**

If the Covered Individual is seeing an in-network provider with her previous carrier, receiving prenatal care, and in or beyond the 20th week of pregnancy, Anthem will consider the current provider in-network.

If the Covered Individual is seeing an out-of-network provider with her previous carrier and this provider is not contracted with Anthem, and the Covered Individual is receiving prenatal care and in or beyond the 20th week of pregnancy, Anthem will consider the current provider in-network.

**Case Management**

The foundations of Anthem’s Case Management (CM) program include a focus on addressing gaps in care, care transition issues, Covered Individual’s self-management plan of care, and effective communication with the physician and Covered Individual’s support system. To achieve this objective, a Nurse Case Manager works in partnership with integrated teams, including the Covered Individual, their caregivers as appropriate, physicians, case management medical directors, pharmacists, behavioral health case managers and others to support a Covered Individual plan of care.

Once a Covered Individual has been identified for potential case management, the Covered Individual is contacted for voluntary program enrollment. The case manager will introduce and describe the program. The Covered Individual can ask questions and
agree or decline to participate. With Covered Individual acceptance of case management, a nurse case manager performs an assessment of needs to identify gaps in care and care transition issues. The assessment includes physical, psychosocial, safety, functional status, knowledge, family and community support; availability of resources and benefits; and potential barriers to achieve optimal outcomes. The case manager contacts the Covered Individual, the family, involved health care service providers, and the treating physician to collaboratively develop a Covered Individual-centric care plan, establish goals and implement interventions designed to meet Covered Individual goals. The initial and subsequent communication ensures the Covered Individual understands their self-management plan of care, his/her significant others are involved in the Covered Individual’s care and they are empowered to make decisions regarding case management plans. This communication supports a more complete and thorough assessment of the Covered Individual’s needs and ensures the Covered Individual concerns or issues are addressed.

If the Covered Individual declines participation, the case manager may work with the health care treatment team to monitor progress through the health care continuum. Case management effectiveness increases with active participation and involvement of the Covered Individual or his or her representative. Opportunities to provide education, to facilitate understanding of the disease process and avoid complications, understand medication regimens and treatment plans, involve community resources, and promote self-advocacy are more effective with active Covered Individual collaboration.

A Covered Individual may self refer or a provider may refer a Covered Individual to Anthem’s Case Management team by calling 888-613-1130.

**Utilization Statistics Information**

On occasion, Anthem may request utilization statistics for disease management purposes using Coded Services Identifiers. This may include, but not limited to:

- Covered Individual name
- Covered Individual identification number
- Date of service or date specimen collected
- Physician name and /or identification number
- Value of test requested or any other pertinent information Anthem deems necessary.

This information will be provided by Provider 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.
Reversals

Utilization Management 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, or;

3. The erroneous determination is caught and corrected expediently.

Quality of Care Incident

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

Audits

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.

Referrals and Pre-certifications

HMO Nevada Referrals

Referrals to in-network specialist are required for some products. If at any time a referral is required for Medically Necessary treatment to an in-network provider a standing referral will be accepted. Although physician specialist office visits may not require a referral, certain in-office services require pre-certification, which providers must obtain by calling the provider pre-certification phone number on the back of the Covered Individual’s health plan ID card.

Surgical procedures, select radiology tests, behavioral health care and chemical dependency rehabilitation services also require pre-certification. The Covered Individual or provider must call Anthem’s behavioral health operations at 800-424-4012 to obtain pre-certification or otherwise coordinate those services.

Covered Individuals must select a PCP and are encouraged to continue coordinating all care through their selected PCP.
HMO Nevada Referrals to Non-participating Providers

HMO Nevada Covered Individuals have out-of-network benefits only for urgent and emergency care or for services pre-certified by HMO Nevada. A referral is required for a Covered Individual to see a non-participating specialist (this doesn’t apply to HMO Nevada POS Covered Individuals who have out-of-network benefits). HMO Nevada’s health case management department staff and/or HMO Nevada’s medical director must approve referrals to non-participating providers before the services are rendered. Referrals to non-participating providers are appropriate only under the following circumstances:

- There is no provider in the HMO Nevada network, based on access, specialty, distance, appointment wait times, etc., who can reasonably provide the service; or
- Emergency care makes using a non-participating provider necessary.

Emergency care is the only justification for retrospective notification (after 48 hours) about the use of a non-participating provider.

When HMO Nevada provides pre-certification for a Covered Individual to be admitted to a hospital, use the emergency room or have outpatient surgery, all services performed for the Covered Individual during the admission, surgery or emergency room visit, including those services performed by non-participating providers, will be paid in accordance with the Covered Individual’s benefits and appropriate reimbursement.

Pre-certifications

Anthem’s pre-certification requirements are consolidated in the Pre-certification Quick Reference Guide (“QRG”). The information in the QRG is available at anthem.com. The QRG doesn’t replace information in your Agreement or in a Covered Individual’s Health Benefit Plan. If you don’t find the information you need here, or by checking Availity (multi-payer) or ProviderAccess (Anthem’s secure Provider portal), please call the provider pre-certification line phone number on the Covered Individual’s health plan ID card.

How to Obtain Pre-certification:

Please have the following information available when you call to request pre-certification:

- Covered Individual’s name, identification number, and date of birth
- Diagnosis, scheduled procedure, and date of admission or expected date of service
- Name of the admitting facility
- Names of the Covered Individual’s PCP and admitting physician
• The Covered Individual’s medical records (Please have them in front of you, because you will be asked specific questions about the Covered Individual’s past treatment and ongoing medical condition. In some cases, you may be asked to submit additional information in writing.)

Upon receipt of the pre-certification request, Anthem’s medical management department staff will:

• Confirm Covered Individual eligibility as of the date of the call.
• Verify the Covered Individual’s insurance coverage.
• Certify a projected length of stay for a scheduled admission and assign a pre-certification number.

If the admission is unscheduled, Anthem’s medical management department staff will designate the case as pending and our utilization review representative will contact the care coordinator at the facility to obtain clinical review so Medical Necessity may be evaluated. Providers will then be notified about the approval or denial. If approved, the pre-certification number and certified number of days will be provided at that time.

**General Rules for Pre-certification:**

**Not all health plans offer the same benefits.** Always confirm benefits that may be available for the Covered Individual at the time of service either online through Availity, ProviderAccess or by calling customer service at the phone number on the Covered Individual’s health plan ID card. **Please note:** Customer service cannot provide pre-certification for services. Providers still must call the pre-certification line phone number on the Covered Individual’s health plan ID card or as listed in the QRG.

**Pre-certification, or the requirement for it, is not a guarantee of benefits.** Once pre-certification is obtained, to facilitate timely and accurate processing of claims, the ordering provider must verify the Covered Individual’s eligibility within two (2) business days before providing services.

**For services obtained from non-participating providers, benefits may not be available, Covered Individual financial responsibility may increase or reimbursement to providers may be reduced, depending on the Covered Individual’s Health Benefit Plan.** If a non-participating provider is delivering services, Anthem strongly advises that the Covered Individual and the non-participating provider call customer service at the phone number on the Covered Individual’s health plan ID card to confirm available benefits and to clarify financial responsibility, which may make it possible to avoid any applicable financial penalties.

**When should pre-certification occur?** In most cases, the ordering physician, who is usually also the treating physician, is responsible for obtaining pre-certification. The provider should make the request before providing services. Failure to obtain timely pre-
certification will result in a denial or reduction in available benefits. Pre-certification should occur as follows:

- At least twenty-four (24) hours before an elective admission or outpatient procedure
- Within seventy-two (72) hours of an urgent or emergency admission
- Within seven (7) days of urgent or emergency care or an unanticipated in-office procedure

Once pre-certification is obtained, payment will be based on the provisions of the Covered Individual's Health Benefit Plan pertaining to the calculation of copayments, deductibles and coinsurance. Changes to the procedures billed or the circumstances of the Covered Individual's case may result in a revision to or reversal of the pre-certification.

**How to Use the Pre-Certification Quick Reference Guide (“QRG”)**

When using the QRG, refer to the alpha prefix (the three alpha characters) at the beginning of the Covered Individual’s ID number to determine if the QRG applies. The Covered Individual’s alpha prefix is on the Covered Individual’s health plan ID card.

**The QRG doesn’t apply to Federal Employee Program (“FEP”) members.** FEP members are identified by an “R” in front of the member ID number on their health plan ID card. For pre-certification for FEP members, please call the following numbers:

- Medical pre-certification: 800-860-2156
- Behavioral health pre-certification: 800-424-4011, press 1, then dial ext. 7140

**Additionally, the QRG doesn’t apply to BlueCard members.** BlueCard members are identified by all alpha prefixes other than those listed on the Alpha Prefix Reference List. For pre-certification for BlueCard members, please call 800-676-BLUE (2583), or check online at anthem.com to be routed to the member’s home plan pre-certification requirements (see details below for information available online).

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Medical Policy, Clinical UM Guidelines, and Pre-cert Requirements tout (blue box on the left side of the page), click the enter button. Select the link titled “Pre-certification/Pre-authorization Requirements (for BlueCard/Out-of-Area Members)”.

The QRG applies to Providers directly contracted with Anthem. Providers contracted through a medical management group must refer to that group’s pre-certification requirements.
The QRG also indicates special pre-certification requirements for specific self-funded employer groups, with group-specific notations in the comments column or in the QRG heading.

The QRG indicates all services that require pre-certification, with the overarching requirement that all inpatient care must be pre-certified. The QRG has a column labeled “STANDARD,” which lists all standard pre-certification requirements. Any product with pre-certification requirements that differ from the standard are listed in columns to the right, under “EXCEPTION” with the product name.

If you have questions, please call the provider pre-certification line at the number listed in the QRG or as listed previously for FEP and BlueCard members.

Pre-Certification QRG is available online

Note: The most current Pre-certification QRG is posted online at anthem.com:

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Medical Policy, Clinical UM Guidelines, and Pre-cert Requirements tout (blue box on the left side of the page), click the enter button. Select the link titled “Pre-certification/Pre-authorization Requirements (for Local Plan Members)”.

Note: The most current Pre-certification QRG is posted online at anthem.com:

- Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Medical Policy, Clinical UM Guidelines, and Pre-cert Requirements tout (blue box on the left side of the page), click the enter button. Select the link titled “Pre-certification/Pre-authorization Requirements (for Local Plan Members)”.

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**Credentialing**

**Credentialing Scope**

Anthem credentials the following contracted health care practitioners: medical doctors, doctors of osteopathic medicine, doctors of podiatry, chiropractors, and optometrists providing Health 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 participating 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 practitioners if the committee member (i) believes there is a conflict of interest, such as direct economic competition with the practitioners; 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 practitioners. Determinations to deny an applicant’s participation, or terminate a practitioners 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 practitioners 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 Networks or Plan Programs on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of costly conditions. Other than gender and language capabilities that are provided to the Covered Individuals to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners/HDOs require additional individual review by the CC are made according to predetermined criteria related to professional conduct and competence as outlined in Anthem Credentialing Program Standards. CC decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process.

Initial Credentialing

Each practitioner/HDO must complete a standard application form when applying for initial participation in one or more of Networks or Plan Programs. This application may be a state mandated form or a standard form created by or deemed acceptable by Anthem. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”), a Universal Credentialing Datasource is utilized. CAQH 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 practitioners. To learn more about CAQH, visit their web site at www.CAQH.org.
Networks or Plan Programs will verify those elements related to an applicants’ legal authority to practice, relevant training, experience and competency from the primary source, where applicable, during the credentialing process. All verifications must be current and verified within the one hundred eighty (180) calendar day period prior to the CC making its credentialing recommendation or as otherwise required by applicable accreditation standards.

During the credentialing process, Networks or Plan Programs 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.

I. 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 TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.</td>
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<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. Practitioners who see Covered Individuals in more than one state must have a DEA/CDS for each state.</td>
</tr>
<tr>
<td>Malpractice insurance</td>
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<tr>
<td>Malpractice claims history</td>
</tr>
<tr>
<td>Board certification or highest level of medical training or education</td>
</tr>
<tr>
<td>Work history</td>
</tr>
<tr>
<td>State or Federal license sanctions or limitations</td>
</tr>
<tr>
<td>Medicare, Medicaid or FEP sanctions</td>
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<tr>
<td>National Practitioner Data Bank report</td>
</tr>
</tbody>
</table>

II. Health Delivery Organizations (HDO’s)

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

The recredentialing process incorporates re-verification and the identification of changes in the Provider’s or Facility’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 Provider’s or Facility’s professional conduct and competence. This information is reviewed in order to assess whether Providers and Facilities continue to meet Anthem credentialing standards.

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

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

Health Delivery Organizations

New HDO applicants will submit a standardized application to Anthem for review. If the candidate meets Anthem screening criteria, the credentialing process will commence. To assess whether Network HDOs, within the scope of the Credentialing Program, meet appropriate standards of professional conduct and competence, they are subject to credentialing and recredentialing programs. In addition to the licensure and other eligibility criteria for HDOs, as described in detail in Anthem Credentialing Program Standards, all 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 occurs every three (3) years unless otherwise required by regulatory or accrediting bodies. Each HDO applying for continuing participation in Plan Programs or Networks must submit all required supporting documentation.

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

Ongoing Sanction Monitoring

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

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

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

Appeals Process

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

When Anthem takes a professional review action with respect to a practitioner's/HDO’s participation in one or more Networks or Plan Programs, 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.

D. 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.

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

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

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

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

5. Current, valid, unrestricted license to practice in each state in which the practitioner would provide care to Covered Individuals;

6. No current license action;

7. No history of licensing board action in any state;

8. No current federal sanction and no history of federal sanctions (per 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. Practitioners who treat Covered Individuals in more than one state must have a valid DEA/CDS for each applicable state.

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/she 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.

i. The applicant agrees that failure to provide the appropriate DEA within a ninety (90) calendar day timeframe will result in termination from the Network.

ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be 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) calendar day timeframe will result in termination from the Network.

(e) AND

(f) 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 or current use of illegal drugs or abuse of 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 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 provider 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 provider’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) calendar days of the date of submission to the CC for a vote;

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

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

5. 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 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. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
   e. nonrenewal of malpractice coverage or change in malpractice carrier related to changes in the carrier's business practices (no
longer offering coverage in a state or no longer in business);
f. previous failure of a certification exam by a practitioner who is currently board certified or who remains in the five (5) year post residency training window.
g. Actions taken by a hospital against a practitioner’s privileges related solely to the failure to complete medical records in a timely fashion;
h. History of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.

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

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

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

Note: the CC will individually review any credentialed Provider and Facility 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”) or the Canadian Association on Social Work Education (“CASWE”).
   b. Program must have been accredited within three (3) years of the time the practitioner graduated.
   c. Full accreditation is required, candidacy programs will not be considered.
   d. If master’s level degree does not meet criteria and practitioner obtained PhD training as a clinical psychologist, but is not licensed
as such, the practitioner can be reviewed. To meet the criteria, the
doctoral program must be accredited by the APA or be regionally
accredited by the Council for Higher Education (“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 time of the practitioner’s graduation.
   b. Registered Nurse license and any additional licensure as an
      Advanced Practice Nurse/Certified Nurse Specialist/Adult
      Psychiatric Nursing or other license or certification as dictated by
      the appropriate State(s) Board of Registered Nursing, if applicable.
   c. Certification by the American Nurses Association (“ANA”) in
psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner or Family Psychiatric and Mental Health Nurse Practitioner.

d. Valid, current, unrestricted DEA Certificate, where applicable with appropriate supervision/consultation by a

e. 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 practitioner will be treating Covered Individuals.

4. Clinical Psychologists:

   a. Valid state clinical psychologist license.

   b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner’s graduation.

   c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.

   d. Master’s level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.

5. Clinical Neuropsychologist:

   a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology (“ABPN”) or American Board of Clinical Neuropsychology (“ABCN”).

   b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.

   c. Clinical neuropsychologists who are not board certified nor listed in the National Register will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:

      i. Transcript of applicable pre-doctoral training OR

      ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate) OR
iii Letters from supervisors in clinical neuropsychology (including number of hours per week) OR
iv Minimum of five (5) years experience practicing neuropsychology at least ten (10) hours per week

III. HDO Eligibility Criteria

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

A. General Criteria for HDOs:
   1. Valid, current and unrestricted license to operate in the state(s) in which it will provide services to Covered Individuals. The license must be in good standing with no sanctions.
   2. Valid and current Medicare certification.
   3. Must not be currently debarred or excluded from participation in any of the following programs: Medicare, Medicaid, or FEHBP.
   4. Liability insurance acceptable to Anthem.
   5. If not appropriately accredited, HDO must submit a copy of its CMS or state site survey for review by the CC to determine if Anthem’s quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:
   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 (“AAPSF”), Accreditation Association for Ambulatory Health Care (“AAAHC”), American Accreditation of Ambulatory Surgery Facilities (“AAASF”), or Institute for Medical Quality (“IMQ”).
   3. Home Health Care Agency: Must be accredited by TJC, Community Health Accreditation Program (“CHAP”) or Accreditation Commission for Health Care (“ACHC”).
   4. Skilled Nursing Facility: Must be accredited by TJC 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, HFAP, NIAHO 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)

**MEDICAL FACILITIES**

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

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

Standards of Participation

Become a contracted Provider or Facility

To learn more about becoming a contracted Provider or Facility, view the steps in the provider application process and download the forms you'll need to apply online. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Become an Anthem Blue Cross and Blue Shield Provider.

Anthem contracts with many types of providers that do not require formal credentialing. However, to become a contracted Provider or Facility, certain standards of participation still must be met. In addition to the insurance requirements listed in the Legal and Administrative Requirements section of this manual, the chart below outlines requirements that must be met in order to be considered for contracting as a contracted Provider or Facility 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>JCAHO, CHAP or ACHC</td>
</tr>
<tr>
<td>Home Infusion Providers</td>
<td>JCAHO, CHAP or ACHC</td>
</tr>
<tr>
<td>Clinical Reference Laboratories</td>
<td>CLIA Certification</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>JCAHO, CHAP, ACHC</td>
</tr>
<tr>
<td>Hearing Aid Supplier</td>
<td>State Licensure</td>
</tr>
<tr>
<td>Home Infusion</td>
<td>JCAHO, CHAP, ACHC</td>
</tr>
<tr>
<td>Hospice</td>
<td>Medicare Certification</td>
</tr>
<tr>
<td>Orthotics &amp; Prosthetics</td>
<td>JCAHO, CHAP, ABC or BOC</td>
</tr>
<tr>
<td>Dialysis Facilities</td>
<td>Medicare Certification</td>
</tr>
</tbody>
</table>

*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 contact your provider contracting representative.*

**Quality Management 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:

1. 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.

2. Upon request, Facility shall also provide Anthem or its designees with reasonable data that are commonly accepted to be indicators of Facility’s quality of care.

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

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

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

- American College of Cardiology (ACC)
- Center for Medicare and Medicaid Services (CMS)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)
- The Joint Commission (JC)
- The Society of Thoracic Surgeons (STS)

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

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

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

Accreditation or Certification

Facility shall be accredited by TJC or the 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:

1. 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 onsite quality assessment of the Facility.

2. 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. If Facility is located in Indiana, Facility shall provide documentation that Facility is a qualified healthcare provider under the Indiana Malpractice Act and documentation of Facility’s participation in the Indiana Patient Compensation Fund.
Program Monitoring

The Anthem Quality Improvement program is designed to fully comply with regulatory and accrediting body requirements for quality improvement. Anthem holds Accreditation from the National Committee for Quality Assurance (“NCQA”) for its Commercial HMO/POS product.

To enable comprehensive assessment of the system and meaningful prioritization of initiatives, the plans select critical monitors from case management, disease management, network management, pharmacy management and UM. The following program components are inherent to the promotion of quality medical and behavioral health care delivery and service:

| • Accessibility of Services | • Medicare Health Outcomes Survey (“HOS”) |
| • Availability of Practitioners | • Member Satisfaction |
| • Consumer Assessment of Healthcare Providers and Systems (“CAHPS®”) | • Member, Practitioner and Provider Communication |
| • Clinical Quality | • Medical Record Audit |
| • Complaints, Grievances and Appeals | • Member Services |
| • Continuity/Coordination of Care | • Patient Safety |
| • Contracting | • Physician Quality |
| • Credentialing/Recredentialing | • Practice Guidelines for Medical, Behavioral Health & Preventive Care |
| • HEDIS | • Provider Satisfaction |
| • Hospital Quality | • Service Quality |

Selection of other areas for monitoring are made by identifying areas of care and/or service that are high in volume, risk, or are problem prone. Selections are made on the probability that such review will have a positive impact on the health and well being of the members. Selection may also be done through industry and business collaboration initiatives including health, state or business coalitions.

As a contracted Provider or Facility with Anthem, you and/or members of your staff will be participating in established quality management activities. Failure to respond to or participate in these activities is a violation of the Agreement and may place the Agreement in jeopardy.
For information about our Quality Improvement program and its goals and performance, go to anthem.com. Click on the green band “Anthem Difference.” Select "Commitment to Quality and Safety." Scroll down to the Quality & Safety section and click “learn more.”

Clinical Practice, Preventive Health, and Behavioral Health Guidelines

We help prevent, manage and improve outcomes for high-volume, high-risk diseases. It’s at the core of our mission to improve the health of the people we serve. That’s why we adopt nationally published clinical practice guidelines developed by some of the nation’s most respected medical organizations. All Anthem-adopted clinical practice guidelines are reviewed and revised annually.

Accreditation bodies, such as the NCQA, require health plans to adopt clinical practice guidelines and to measure performance against these guidelines. Similarly, Anthem requires Providers and Facilities to adopt the Anthem practice guidelines. A complete list of the guidelines is available at anthem.com. Select the “Provider” link in the upper left corner of page. Choose “Nevada” from the drop down list and enter. From the Provider Home page, select Health & Wellness tab, then the link titled “Practice Guidelines”.

Currently adopted national clinical practice guidelines include the following:

- Asthma – guidelines for the diagnosis and management of asthma
- Heart failure (“HF”) – guidelines for the diagnosis and management of chronic heart failure in adults
- Diabetes – standards for medical care in diabetes
- CAD – guidelines for secondary prevention for patients with coronary and other atherosclerotic vascular disease and the treatment of hypertension in the prevention and management of ischemic heart disease
- COPD – Global Initiative for Chronic Obstructive Lung Disease (“GOLD”) guidelines for the Global Strategy for the diagnosis, management, and prevention of chronic obstructive pulmonary disease
- CAD (for women) – guidelines for cardiovascular disease prevention in women
- CKD – guidelines for chronic kidney disease
- Maternity/Perinatal – guidelines for perinatal care
- Musculoskeletal Low Back pain – guidelines for diagnosis and treatment of low back pain in adults
- Musculoskeletal Osteoarthritis – guidelines for the medical management of osteoarthritis of the hip and knee
- Musculoskeletal Osteoporosis – guidelines for the screening and treatment and prevention of osteoporosis
- Musculoskeletal Rheumatoid – guidelines for the management of rheumatoid arthritis
- Oncology – guidelines for breast, colon prostate, non-melanoma skin, melanoma skin, and nutrition and physical activity during and after cancer treatment
- Vascular at Risk-Hyperlipidemia – guidelines for the detection, evaluation, and treatment of high blood cholesterol in adults
- Vascular at Risk – Hypertension – guidelines for the prevention, detection, evaluation, and treatment of high blood pressure
- Vascular at Risk-Metabolic Syndrome – guideline for the diagnosis and management of metabolic syndrome

Currently Anthem-developed and adopted guidelines include:

- Preferred Practice Guidelines, Identification and Treatment of Adult Depressive Disorder.
- Preferred Practice Guidelines for the Evaluation and Treatment of Children with Attention Deficit/Hyperactivity Disorder (“ADHD”).
- Preferred Practice Guidelines for the Identification and Treatment of Substance Use Disorder (“SUD”).
- Preferred Practice Guidelines for the Treatment of Bipolar Disorder.
- Identification and Treatment of Antenatal Depression (“AND”), Postpartum Depression (“PPD”) and Postpartum Psychosis (“PPP”).

**Preventive care**

- Preventive Care and Immunization Guideline for Children and Adults.

**Health Promotion and Wellness**

**Online Health Information**

An online health information service, MyHealth@Anthem powered by WebMD®, is available at anthem.com to all Anthem members, employers, Providers and Facilities and website visitors. It offers valuable tools, such as access to health information in English and Spanish, an easy-to-use health assessment tool, in-depth condition centers, and a variety of mini quizzes and health trackers. All content is physician-reviewed for medical accuracy.

**Nevada State Health Division’s Immunization Registry (Nevada WebIZ)**

In 2007, the Nevada State Legislature passed bill NRS 439.265 requiring that effective July 1, 2009 any provider who administers an immunization to a child must report specific information to the Nevada State Health Division’s Immunization Registry (Nevada WebIZ). Nevada WebIZ is a confidential online data-base that stores immunization records for both children and adults, keeps records in one secure location, allows registered providers to gain access and reduces duplicate vaccinations and scattered immunization records along with many other benefits.
**Highlights of the Nevada Immunization Registry WebIZ Program include:**

- Easily and quickly retrieves immunization records of clients seen at your office
- Consolidates vaccinations from all providers into one printable official record
- Reduces duplicate immunizations with access to clients’ immunization histories
- Forecasts immunizations due at time of visit based on current recommendations. (Using ACIP Schedule)
- Assesses your current levels of immunization coverage
- Produces reminders and recall lists for immunizations that are due or overdue
- Facilitates vaccine inventory control (captures lot # data on patient records allowing instant patient recall)
- Produces reports including client counts, doses delivered and vaccine usage
- HIPAA compliant—all data is encrypted

The Nevada State Health Division hosts WebIZ. Access to the internet and the usage of the Web Browser Internet Explorer and Adobe Acrobat Reader are required for WebIZ. No other special software is required.

Training on this program is provided at no cost to the user. If you have questions or would like to sign up for training call 877-689-3249.

**Revised Random Medical Record Review Process**

Our random medical record review ("MRR") process has undergone some revisions in 2009 and 2010. This impacted our network PCPs. The goal was to adopt one MRR process across our organization.

Our company has medical record standards that require practitioners to maintain medical records in a manner that is current, organized and facilitates effective and confidential member care and quality review. We perform medical record reviews to assess network PCPs’ compliance with current medical record standards recognized by the NCQA. All reviews are conducted by a nurse under the supervision of the local Medical Director.

These MRRs historically have been performed annually on a percentage of randomly chosen PCPs identified through claims and the Healthcare Effectiveness Data and Information Set (“HEDIS®”) process and contracted with our managed care products. These products include HMO, POS, PPO, Medicare Advantage, and Medicaid. Typically, the timeline for this process is June through September annually. In order to pass the review, an office must score eighty percent (80%) or greater. If a practitioner fails to meet the company’s standard of eighty percent (80%), a re-review is conducted within six (6) months. Our MRR process is currently underway for 2010. Data results from this quality program will be available later this year, for your review.
MRRs are not required if the PCP’s office has Electronic Medical Records (“EMR”) or their office has been recognized by the NCQA Physician Practice Connection Program.

There are two (2) sections on the audit tool: Office Specific Questions (written policies) and Chart Elements/Content and Clinical Documentation (organization of medical records and preventive health service documentation).

Advance directives reminder: Please remember to include documentation of an advance directive in a prominent part of a Medicare Advantage member’s medical record, and include a copy of the directive in the medical record. For more information on Medical Record Standards, log on to anthem.com. Select the “Provider” link in the upper left corner of page. Choose “Nevada” from the drop down list and enter. From the Provider Home page, select Health & Wellness tab, then the link titled “Quality”, then “Medical Records Review.”

Thank you for your assistance with participating in this very important quality initiative these past years. We look forward to working collaboratively with you on other quality programs, such as HEDIS®.

HEDIS® is a registered trademark of the NCQA.

Medical Record Standards: Office-Specific Questions

1. A documentation system is in place to follow up on missed appointments.
2. A system is in place to schedule appropriate preventive health services (i.e., reminder system).
3. Medical records are kept in a secure area away from public access, accessible only to authorized personnel.
4. Medical records are easily retrievable by office personnel, with legible file markers.
5. Written policy addresses confidentiality of patient information, with evidence that staff receives periodic training in member information confidentiality i.e., policy, training sessions log, etc.
6. Written policy addresses release of patient information and demonstrates confidentiality of all patient information in accordance with applicable state and federal laws, with evidence of continued office staff training on confidentiality.
7. Written policy addresses signed, informed consents; documentation is present and dated, when appropriate.
8. Written policy or statement in place relating to primary language and linguistic service needs of non-or-limited English proficient (“LEP”) or hearing-impaired members; such needs are prominently noted. Member refusal of interpreter services must be documented.
9. Written policy addresses that the office does not discriminate in the delivery of health care services by factors such as race, ethnicity, national origin, religion, sex, age, evidence of insurability, and accepts for treatment any member in need of the health care services they provide.

10. Written policy addresses prompt transfer of patient care records to other in- or out-of-network providers for the member's medical management.

11. Written policy addresses that medical records are retained for a period of seven (7) years after last patient encounter.

12. ****SC SSB Only:**** Retention period is ten (10) years for adults and thirteen (13) years for minors.

13. ****GA Only:**** Six (6) years after the last patient encounter or six (6) years after the patient turns age eighteen (18).

**Chart Elements/Content and Clinical Documentation**

1. Every page in the record contains the patient name or ID number.

2. There is one (1) chart per patient.

3. The chart is organized and the pages secured.

4. Biographical data include name, ID number, date of birth, address, employer and address, home and work telephone numbers, emergency contact information, ethnicity, gender and marital status, as applicable, or the refusal to provide this information by the patient, parent or legal guardian, is noted in the medical record.

5. Missed or canceled appointments, along with follow-up contact and outreach efforts, is noted in the medical record.

6. Allergies/NKDA and adverse reactions are prominently displayed in a consistent location.

7. All presenting symptom entries are signed and dated, including phone entries. Dictated notes should be initialed to signify review. Signature sheet for initials are noted.

8. All presenting symptom entries are legible, including phone entries, to someone other than the writer. Signature sheet for initials are noted.

9. A problem list is maintained and updated for significant illnesses and medical conditions.

10. A medication list or reasonable substitute is maintained and updated for chronic and ongoing medications.

11. Past medical history is current and easily identified for patients seen three (3) or more times and includes: family history, serious accidents, surgeries and illnesses. Childhood history includes prenatal care, birth operations and childhood illnesses. This information should be updated every two (2) years.
12. For patients eleven (11) years and older, appropriate notation appears annually concerning the use of cigarettes, alcohol and substances.

13. For patients eleven (11) years to twenty-one (21) or if relevant, there is appropriate notation concerning sex education, including such topics as abstinence, S.T.D., pregnancy prevention, use of condoms, etc.

14. History and physical exam identifies appropriate subjective and objective information pertinent to the patient’s presenting symptoms, and treatment plan is consistent with findings.

15. Laboratory tests and other studies are ordered, as appropriate, with results noted in the medical record within fourteen (14) calendar days of completion of services.

16. Encounter forms or notes have a notation, when indicated, regarding follow-up care, calls or visits. The specific time is noted in weeks, months or as needed.

17. Unresolved problems from previous office visits are addressed in subsequent visits.

18. Documentation of advance directive/Living Will/Power of Attorney discussion in a prominent part of the medical record for adult patients who are Medicare Advantage members; and documentation on whether or not the patient has executed an advance directive with a copy to be included in the medical record. (We also encourage providers to maintain documentation of advance directive discussions and copies of executed advance directives in patients’ files for other, non-Medicare Advantage members.)

19. Continuity and coordination of care between the PCP, specialty physician (including behavioral health specialty) and/or facilities is shown. A summary of findings or discharge summary is requested and is in the medical record. Examples include progress notes/report from consultants, discharge summary following inpatient care or outpatient surgery, physical therapy reports, and home health nursing provider reports.

20. Physician reviews and follow-up is documented when needed on all consultants, lab and test results. (Evidenced by MD initials and date on results or consultant letter.)

21. Indication that the patient has been notified of abnormal test or lab results and explicit follow-up plans for all abnormal labs or test results.

22. Is there documentation of anticipatory guidance discussion regarding depression/anxiety, beginning at seven (7) years of age and/or sooner or at any time the physician feels the need for referral.

   □ Depression/anxiety
   □ Behavioral/developmental screening: general screening (i.e., PEDS or other tool) school readiness activities (risk level) for all ages.

23. Age appropriate routine preventive services/risk screening is consistently noted, i.e. childhood immunizations, adult immunizations, mammograms, pap
tests, etc., or the refusal by the patient, parent or legal guardian, of such screenings/immunizations in the medical record.

For those patients with any of the following:

- Diabetes
- Post MI/Cardiac event
- CAD
- COPD
- 2 plus medical conditions

24. Is there evidence that the PCP screened for the presence of depressive symptoms? Please include the screening method (e.g., interview, use of tool, etc.). (Non-scored)

25. Is there evidence that the PCP screened for the presence of alcohol abuse symptoms? Please include screening method (e.g., CAGE, AUDIT, AUDIT-C, BMAST, TWEAK, medical history, progress note, other). (Non-scored)

26. Is there evidence that the PCP screened for depression? Please include the screening method (e.g. PHQ-9, HADS, GHQ, Beck, Zung, HAM-D, CES-D, Whooley, medical history, progress note). (Non-scored)

27. Health education appropriate to the patient is provided and documented in the medical record.

28. Errors are corrected according to legal medical documentation standards as follows:

- Draw line through entry, the inaccurate information must remain legible.
- Initial and date entry.
- State the reason for the error (i.e., in the margin or above the note as room permits).
- Document the correct information. Document the current date and time referring back to the incorrect entry.

**Member Quality of Care (“QOC”) Investigations**

The quality management department develops, maintains and implements policies and procedures for identifying, reporting and evaluating potential quality of care/service concerns or sentinel events involving Anthem members. This includes cases reviewed as the result of a grievance submitted by a member and high-risk cases reviewed as the result of a referral received by an Anthem clinical associate. All Anthem associates who may encounter clinical care/service concerns or sentinel events are informed of these policies. Criteria are developed to indicate which cases require referral to a medical director and/or the Credentialing Committee. The quality management committee annually reviews these cases for trends and improvement opportunities. The quality
council reviews these trends annually during the process of prioritizing quality improvement activities for the subsequent year.

Quality issues are generally investigated by requesting medical records and/or a response from the involved provider or medical group. After reviewing the circumstances of the case, a clinical associate in collaboration with the medical director or his or her designee, may determine that a quality of care/service concern or sentinel event does not exist. If that occurs, the case is closed with a severity level 0 for tracking and trending. If the case is a member grievance, the member is sent a resolution letter within thirty (30) calendar days of Anthem’s receipt of the grievance. The member is informed that peer review statutes do not permit disclosure of the details and outcome of the quality investigation. Cases reviewed with "no quality of care issue" identified will be trended at least annually for review by the credentialing committee.

The medical director and/or the credentialing committee will determine the severity level of a member quality of care/service or sentinel event. In certain circumstances, a clinical peer review may be needed for specialty consultation. Upon completion of the review, the quality management associate will send a letter to the provider explaining the outcome of the review and requesting the provider’s response to an identified quality concern. In addition, the provider is advised that the credentialing committee will review trends/patterns per calendar year for its corrective action recommendations. Trends/patterns of all assigned severity levels are reviewed with the medical director and credentialing committee for intervention and corrective action planning. As part of the credentialing/re-credentialing process, the quality management associate will submit any clinical quality of care/service cases or sentinel events to the credentialing committee for review. The quality management clinical associate will submit clinical quality of care/service or sentinel events to medical management groups to whom credentialing has been delegated for their credentialing/re-credentialing review.

**Severity Levels for Quality Assurance**

*Quality of Care ("QOC"):*

<table>
<thead>
<tr>
<th>Level</th>
<th>Points Assigned</th>
<th>Leveling Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>No QOC or Administrative issue found to exist.</td>
</tr>
</tbody>
</table>
| 1     | 0               | Recognized Medical or Surgical complication that may occur in the absence of negligence and **without** QOC concern.  
  
(Examples could be a post-operative wound infection or an unexpected adverse reaction to a medication) |
<p>| 7     | 5               | Communication or administrative issue with no adverse medical effect on the member. |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(Examples could be a miscommunication, an administrative error which caused confusion, unprofessional comment, failure to return a patient’s phone calls, failure to respond to a member grievance despite two (2) requests per internal guidelines).</td>
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<tr>
<td>2</td>
<td>10</td>
<td>A clinical issue that would be judged by a prudent professional to be mildly to moderately beneath the community standard. (Examples could be failure to change antibiotics for UTI after culture &amp; sensitivity report reveals resistance and patient is hospitalized for pyelonephritis; failure to assess for and recognize substance abuse issues in a member presenting for treatment of depression or failure to refill a member’s prescriptions in a timely manner.)</td>
</tr>
<tr>
<td>3</td>
<td>25</td>
<td>A clinical issue that would be judged by a prudent professional to be significantly beneath the community standard. (Examples would be wrong surgery site or failure to perform cardiac testing in high risk middle aged smoker with chest pain or failure to perform appropriate risk assessment on a member presenting with severe depression.)</td>
</tr>
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</table>

**Quality of Service**

<table>
<thead>
<tr>
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<th>Points Assigned</th>
<th>Leveling Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>0</td>
<td>No quality of service or Administrative issue found to exist. Assign this level to grievances regarding the condition or appearance of a practitioner’s office.</td>
</tr>
<tr>
<td>7</td>
<td>5</td>
<td>Communication or administrative issue with no adverse medical effect on the member. (Examples could be a miscommunication, an administrative error which caused confusion, unprofessional comment, failure to return a patient’s phone calls, failure to respond to a member grievance despite two (2) requests per internal guidelines).</td>
</tr>
<tr>
<td>Level</td>
<td>Points Assigned</td>
<td>Leveling Description</td>
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</tr>
<tr>
<td>6</td>
<td>25</td>
<td>Confirmed discrimination, confirmed HIPAA violation, or other significant provider quality of service issues that would warrant immediate referral to the Provider Review Committee.</td>
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</table>

**Trend Threshold**

Any combination of cases totaling fifteen (15) points or more, and/or any of the following cases identified over a rolling twelve (12) month timeframe will be subject to trend analysis:

- 8 cases with a leveling of 0
- 4 cases with a leveling of 1
- 4 cases with a leveling of 7
- 2 cases with a leveling of 2
- 1 cases with a leveling of 3 (automatic referral to the Peer Review Subcommittee)
- 4 cases with a leveling of 6 (automatic referral to the Provider Review Committee)

A written corrective action plan may be required from a provider who meets the above trend threshold or for whom a clinical quality of care/service or sentinel event has been found. A complete corrective action plan must include the following standard elements:

- Mutually agreeable and achievable actions to be taken by the provider
- Specific time periods during which the provider will take the stipulated actions
- Specific measures by which the provider will be evaluated and dates or times on which the evaluation(s) will occur
- A corrective action plan report submitted to the credentialing committee by the quality management/UM clinical liaison at its next scheduled meeting

Anthem’s quality management team will review all corrective action plans. If this review indicates the corrective action plan is unacceptable, Anthem’s quality management medical director will review the plan. If the medical director agrees that the corrective action plan is inadequate, it will be returned to the provider with comments on the elements needed for an adequate corrective action plan before the provider resubmits the plan. Actions required to be taken as part of a corrective action plan may include, but are not limited to, sanctions, continuing education and in-depth practice monitoring with specific timeframe requirements.

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

Release of Information/Confidentiality

Members should expect that Anthem and its Providers and Facilities will protect their right to privacy in all care settings.

All records relating to the health care of Anthem members or containing protected health information (“PHI”) as defined by HIPAA, including PHI stored in written, electronic or oral format throughout the Anthem organization, are completely confidential. Confidential information is maintained behind locked doors with key card access and in locked storage (where appropriate) except during business hours. Providers may request a copy of Anthem’s confidentiality policy at any time. Disclosure of information relating to substance and alcohol abuse is subject to federal regulations governing such disclosure. Members may request to review their medical record data. Data will not be released to employers in a member-identifiable format.

Anthem will not release any confidential, member-identifiable information outside the organization, except as allowed by applicable regulations and federal and state laws, without obtaining the member’s written permission on a special consent authorization form.

Anthem has legal authority to access members’ medical records for the purpose of health care operations functions, including quality management and UM purposes. At the time of contracting, providers agree to release medical records for purposes of quality management and UM. The medical information releases entitle Anthem to access to medical records information at the PCP’s office and specialist’s office, and hospital inpatient records, outpatient records and records for other ancillary services provided to members for purposes of quality management and UM. Anthem may also request copies of medical records. Members participating in studies will be asked to sign a special consent authorization form, prior to release of their data, when the data is to be used for purposes outside normal health care operations or when release of the data is allowed and/or required by state or federal law.

Conflict of Interest

Providers participating in Anthem’s quality management program may not review a case in which the provider has a conflict of interest. Conflicts of interest may be personal or financial in nature. Examples of personal conflicts of interest include, but are not limited to, cases in which the reviewer has been the attending or consulting physician or when a family relative or friend is involved. Financial conflicts may occur when the reviewer has relationships or investments in particular health care facilities or treatment modalities.
360° HEALTH®

What is the 360° Health Program?

It's one of the industry's most comprehensive health services programs. In fact, this integrated group of health services is designed to help you and our members:

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

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

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

In a nutshell, 360° Health includes tools your patients and their family can use to manage their health care needs.

Centers of Medical Excellence Transplant Network

Anthem Centers of Medical Excellence ("CME") Transplant Network

The CME designation is awarded by Anthem to those programs meeting the participation requirements for Anthem’s transplant network and all other future specialty networks developed by Anthem. 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 eighty (80) facilities nationwide – representing more than three hundred thirty (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)

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Member Grievance and Appeal Process

**Member Rights and Responsibilities**

As a Health Plan Member you have certain rights and responsibilities to help make sure that you get the most from your plan and access to the best care possible. That includes certain things about your care, how your personal information is shared and how you work with us and your Doctors. It’s kind of like a “Bill of Rights”. And helps you know what you can expect from your overall health care experience and become a smarter health care consumer.

**You have the right to:**

- Speak freely and privately with your Doctors and other health professionals about all health care options and treatment needed for your condition, no matter what the cost or whether it’s covered under your plan.
- Work with your Doctors in making choices about your health care.
- Be treated with respect, dignity, and the right to privacy.
- Privacy, when it comes to your personal health information, as long as it follows state and Federal laws, and our privacy rules.
- Get information about our company and services, and our network of Doctors and other health care providers.
- Get more information about your rights and responsibilities and give us your thoughts and ideas about them.
- Give us your thoughts and ideas about any of the rules of your health care plan and in the way your plan works.
- Make a complaint or file an appeal about:
  - Your health care plan
  - Any care you get
  - Any covered service or benefit ruling that your health care plan makes
- Say no to any care, for any condition, sickness or disease, without it affecting any care you may get in the future; and the right to have your Doctor tell you how that may affect your health now and in the future.
- Participate in matters that deal with the company policies and operations.
- Get all of the most up-to-date information about the cause of your illness, your treatment and what may result from that illness or treatment from a Doctor or other health care professional. When it seems that you will not be able to
understand certain information that information will be given to someone else that you choose.

You have the responsibility to:

- Choose any primary care physician (doctor), also called a PCP, who is in our network if your health care plan says that you to have a PCP.
- Treat all doctors, health care professionals and staff with courtesy and respect.
- Keep all scheduled appointments with your health care providers and call their office if you have a delay or need to cancel.
- Read and understand, to the best of your ability, all information about your health benefits or ask for help if you need it.
- To the extent possible, understand your health problems and work with your Doctors or other health care professionals to make a treatment plan that you all agree on.
- Follow the care plan that you have agreed on with your Doctors or health care professionals.
- Tell your Doctors or other health care professionals if you don’t understand any care you’re getting or what they want you to do as part of your care plan.
- Follow all health care plan rules and policies.
- Let our Member Service department know if you have any changes to your name, address or family members covered under your plan.
- Give us, your Doctors and other health care professionals the information needed to help you get the best possible care and all the benefits you are entitled to. This may include information about other health care plans and insurance benefits you have in addition to your coverage with us.

We are committed to providing quality benefits and customer service to our members. Benefits and coverage for services provided under the benefit program are governed by the Subscriber Agreement and not by this Member Rights and Responsibilities statement.
Member Appeals

Complaints, Grievances and Appeals

This section explains what to do if a member disagrees with Anthem’s denial, in whole or in part, of a claim, requested service or supply, and how to file a complaint, appeal or grievance with Anthem.

Complaints

If the member has a complaint about any aspect of Anthem’s services or claims processing, the member should contact Anthem’s customer service department at:

Anthem Blue Cross and Blue Shield
Customer Service Department
P.O. Box 17549
Denver, CO 80217-7549

If the member has questions regarding eligibility or membership, the member should contact Anthem’s customer service department at:

Anthem Blue Cross and Blue Shield
P.O. Box 172405
Denver, CO 80217-2405

A trained representative will work to clear up any confusion and resolve the member’s concerns. If the member is not satisfied with the resolution, the member can file an appeal as explained under the Appeals heading in this section.

Appeals

While Anthem encourages members to file appeals within 60 days of the adverse benefit determination, the written or oral appeal must be received by Anthem within 180 days of the adverse benefit determination. Appeals may be for pre-service denials or post-service denials. Anthem will assign an employee to assist the member in the appeal process. The member may send written appeals to:

Anthem Blue Cross and Blue Shield
Appeals Department
P.O. Box 10330
Reno, NV 89520-0030

The appeal must state plainly the reason(s) why the member disagrees with Anthem’s claim decision, Anthem’s refusal to authorize or cover a requested service or supply, or how Anthem calculated the benefit. The member should include any documents not originally submitted with the claim or request for the service or supply.
and any other information that the member feels may have a bearing on the decision.

Through the appeal process, the member can access two levels of appeal, and, where appropriate, independent external review. The member can designate a representative (e.g., the member’s physician or anyone else of the member’s choosing) to assist the member with filing any level of appeal. In some instances, Anthem may ask the member to designate the member’s representative in writing. The member or the member’s representative can review the member’s appeal file on request, and can present evidence as part of the appeal process.

**Level 1 Appeal** — This is an appeal in which the Anthem Appeal Board reviews the appeal and makes a determination. The majority of the Appeal Board are members who receive health care benefits from Anthem and who were not involved in the initial adverse benefit determination, but a person who was previously involved with the denial may answer questions. The Appeal Board will make its determination within 30 days after receipt of the appeal, unless the member agrees to a longer period. The member will receive written notification of the Appeal Board’s determination, with the reasons for its decision.

**Level 2 Appeal** — If the Level 1 Appeal decision is not satisfactory, and if allowed by the terms of the member’s health plan, the member can (but does not have to) file a Level 2 Appeal. The member has 60 days from receiving the Level 1 Appeal decision in which to request a Level 2 Appeal. The panel of the Level 2 Appeal Board includes a minimum of three people. The majority of the Level 2 Appeal Board are members who receive health care benefits from Anthem. At the Level 2 appeal, the member or the member’s representative may appear or be teleconferenced in to present information. A person who was previously involved may be a member of the Level 2 Appeal Board to present information or answer questions. Anthem will provide the member with a copy of the Level 2 Appeal Board’s written decision within 30 days after receipt of the appeal request, unless the member agrees to a longer period of time. Anthem will provide a copy of the decision to any provider who submits a Level 2 Appeal on the member’s behalf.

**Expedited Level 1 Appeal** — A member or member’s representative has the right to request an expedited appeal when the time frames for a standard review could: (1) seriously jeopardize the member’s life or health; (2) jeopardize the member’s ability to regain maximum function; or (3) if the member has a disability, create an imminent and substantial limitation on the member’s existing ability to live independently. Expedited appeals will be resolved as quickly as medical circumstances require, but not later than 72 hours after receipt of the request. Except as mentioned below, expedited appeals are not available when the service or supply in question has already been provided to the member.

**Independent External Review Appeal** — If Anthem’s decision involved making a judgment as to the medical necessity, appropriateness, health care setting, level of
care or effectiveness of the health care service or treatment the member requested, the member may have the right to Independent External Review, where Anthem’s decision will be reviewed by health care professionals who have no association with Anthem. The member may also request an Independent External Review when a claim has been denied based upon a determination that the recommended or requested health care service or treatment is experimental or investigational treatment. Except as noted below, in order to request an Independent External Review, the member must have first completed a Level 1 Appeal, but the member can make such a request either after or instead of choosing to file a Level 2 Appeal. But if Anthem fails to respond to a complaint or appeal within thirty (30) calendar days, and the member has not agreed to an extension, the member can request an Independent External Review and the member will be considered to have exhausted the internal appeals process. Also, in some instances, Anthem may (but is not required to) agree to an Independent External Review even if the member has not exhausted the Level 1 Appeal.

The request for Independent External Review must be made to the Nevada Office of the Governor, Consumer Health Assistance within four months after the adverse benefit determination [or our final appeal determination, whichever is later]. Except as mentioned below for expedited external review appeals, the request must be in writing on a form available through the Office of Consumer Health Assistance, which can be contacted at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

- Within 5 business days after receiving the request for external review, the Office of Consumer Health Assistance shall notify the member, Anthem and other interested parties that a request for external review has been filed.
- As soon as practical, the Office of Consumer Health Assistance shall assign the Independent Review Organization.
- Within 5 business days after receiving the assignment from the Office of Consumer Health Assistance identifying the Independent Review Organization, Anthem shall provide all documents and materials relating to the adverse determination to the Independent Review Organization.
- Within 5 days after receiving notification from the Office of Consumer Health Assistance and the materials from Anthem, the Independent Review Organization will review the materials and notify the member if additional information is needed to conduct the review.
- Additional information must be provided within 5 days after receiving the request.
- The Independent Review Organization shall forward a copy of the additional information to Anthem within 1 business day after receipt.
• Within 15 days of completing the review, the Independent Review Organization shall submit a copy of its determination to the member.

When the member or the member’s representative request Independent External Review, the member will be required to authorize the release of any medical records that may be required to be reviewed for the purpose of reaching a decision.

Not all requests will be eligible for Independent External Review. If the member’s claim is determined to be not eligible for Independent External Review, the member will be notified of that decision. However, if your denial is eligible for Independent External Review, an Independent Review Organization will be assigned to conduct the review and issue a decision.

Expedited Independent External Review Appeals — An expedited review may be requested from the Office of Consumer Health Assistance when: (1) an adverse benefit determination concerns an admission, availability of care, continued stay or health care service for which the member received emergency services but has not been discharged from the facility providing the services or care; or (2) failure to proceed in an expedited manner may jeopardize the life or health of the member or the member’s ability to regain maximum function; or (3) if the claim has been denied based upon a determination that the service or treatment is experimental or investigational, the member’s treating physician certifies in writing that the recommended service or treatment would be significantly less effective if not promptly initiated. Typically, a member must complete a Level 1 Appeal prior to requesting external review. However, if the adverse determination involves a denial based on a determination that the service or treatment is experimental or investigational and the treating physician certifies in writing that the service or treatment would be significantly less effective if not promptly initiated, and, if the member has a medical condition where the time to complete an Expedited Level 1 Appeal would seriously jeopardize the member’s life, health or ability to regain maximum function, then the member or member’s representative can request Expedited Independent External Review at the same time as requesting an Expedited Level 1 Appeal. If eligible for Expedited Independent External Review, the Independent Review Organization assigned to the member’s case will then determine whether the Independent External Review should be decided before the member’s Expedited Level 1 Appeal.

• The Office of Consumer Health Assistance shall approve or deny a request for an expedited external review within 72 hours after it receives proof of whether the request qualifies for expedited external review.

• Upon determination that the request is eligible for an expedited external review, Office of Consumer Health Assistance shall assign an Independent Review Organization within 1 working day after approving the request.
• Anthem shall provide all documents and information used to make the adverse
determination to the Independent Review Organization within 24 hours after
receiving notice from the Office of Consumer Health Assistance assigning the
request.
• The Independent Review Organization must complete its review within 48 hours
(unless the member and Anthem agree to a longer period) after receiving the
assignment.
• Within 24 hours after completing the assignment, the Independent Review
Organization must notify the member, physician and Anthem of its determination
by telephone, followed up in writing within 48 hours.

The member or the member’s provider can request (orally or in writing) an Expedited
Independent External Review. Requests for Expedited Independent External
Review must be made to the Office of Consumer Health Assistance within four
months of an adverse benefit determination or our final appeal determination,
whichever is later. The Office of Consumer Health Assistance can be reached at:

555 E. Washington Ave., Ste. 4800
Las Vegas, NV 89101
Phone: 702-486-3587 Fax: 702-486-3586
Toll Free: 1-888-333-1597

When the member or the member’s representative request Independent
External Review, the member will be required to authorize the release of any
medical records that may be required to be reviewed for the purpose of
reaching a decision.

Not all requests will be eligible for Independent External Review. If the member’s
claim is determined to be not eligible for Independent External Review, the member
will be notified of that decision. However, if your denial is eligible for Independent
External Review, an Independent Review Organization will be assigned to conduct
the review and issue a decision.

Appeals Involving Independent Medical Evaluations - If Anthem requires an
independent medical or chiropractic evaluation to make a final determination of
benefits or care, Anthem may require the member to submit to the independent
medical evaluation. The evaluation will be conducted by a physician or chiropractor
who is certified to practice in the same field of practice as the primary treating
physician or chiropractor, or who is formally educated in that field.

The independent evaluation must include a physical examination of the patient,
unless deceased, and a personal review of all x-rays and reports prepared by the
primary treating physician or chiropractor. A certified copy of all reports of findings
must be sent to the primary treating physician or chiropractor and the member within
10 working days after the evaluation. If the member disagrees with the findings of
the evaluation, the member must submit an appeal to Anthem, pursuant to the procedure for binding arbitration as established by the American Arbitration Association, within 30 days after receipt of the findings of the evaluation. Upon receipt of an appeal, Anthem will notify the primary treating physician or chiropractor in writing.

Anthem will not limit or deny coverage for care related to a disputed claim that requires an independent medical evaluation while the dispute is in arbitration. However, if Anthem prevails in the arbitration, the primary treating physician or chiropractor may not recover any payment from Anthem, the subscriber or the patient for services that the physician or chiropractor provided to the patient after receiving written notice from Anthem.

Grievances

The member may send a written grievance to:

    Anthem Blue Cross and Blue Shield
    Quality Management Department
    P.O. Box 4310
    Woodland Hills, CA 81365

Anthem’s Quality Management Department will acknowledge receipt of, and investigate, the member’s grievance. Anthem treats each grievance investigation in a strictly confidential manner.

Legal Action

Before a member takes legal action on a claim decision, the member must first follow the process outlined under the heading Appeals in this section and the member must meet all the requirements of this certificate.

No action in law or in equity shall be brought to recover on this certificate prior to expiration of 60 calendar days after a claim has been filed in accordance with the requirements of this certificate. No such action shall be brought at all unless brought within three years after claim has been filed as required by the certificate.

_The appeals process as defined above is for local claims and may or may not be the process by which National Account claims are handled. These processes would be determined by the individual home plans based on their internal processes and may also be based on member or group contracts._

How a Member can Obtain Language Assistance

We are committed to communicating with our Members about their health plan, regardless of their language. We employ a Language Line interpretation service for use
by all of our local member Customer Service Call Centers. The Member may simply call the Customer Service phone number on the back of their ID card and a representative will be able to assist them. Translation of written materials about their benefits can also be requested by contacting customer service. TTY/TDD services also are available by dialing 711. A special operator will contact Anthem to help with member needs.

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**Provider Complaint and Dispute Resolutions (Appeals) Process**

**Provider Dispute Resolution (Appeals)**

**Policy Statement**

Provider-carrier dispute resolution requests must be submitted to Anthem’s provider appeals department in writing or on the [Provider Dispute Resolution Form](#). Providers have one year from the date of the original EOB or RA to dispute a claims adjudication action. Provider-carrier dispute means an administrative, payment or other dispute between a participating provider and a carrier that does not involve a utilization review analysis and does not include routine provider inquiries that the carrier resolves in a timely fashion through existing informal processes (i.e., through customer service or submission of a [Claim Action Request Form](#)).

The Provider dispute resolution process is available for administrative and payment issues only. For Local Plan claims, if your dispute involves utilization review (UR), it is not available for review as a provider appeal. However, Anthem will have an appropriate individual reconsider the UR decision in light of your concerns and notify you of the outcome. Also or instead, members may appeal UR decisions in accordance with the member appeals process. For BlueCard claims, provider disputes are filed directly to the local blue plan (Nevada). If the BlueCard provider dispute is regarding the member’s benefits, and the provider is appealing on a member’s behalf, appeals are coordinated with the member’s benefit office for final determination.

Anthem shall make a determination of a provider dispute resolution request within thirty (30) calendar day of receipt of all necessary information. When Anthem does not receive all necessary information to make a decision, Anthem shall request in writing within thirty (30) calendar days of receipt of the request the additional information needed. Anthem shall allow thirty (30) calendar days from the date of the request to receive the requested information. If the provider does not respond within the thirty (30) calendar day timeframe, Anthem shall close the request without further review. Further consideration of the closed provider dispute resolution request must begin with a new request by the provider.

BlueCard Member appeals are filed directly to the home plans and time frames are determined by the member’s home plan. BlueCard provider appeals are processed through the adjustment department and are not bound by time limits designated by state
legislation. Benefit appeals are forwarded to the member’s home plan and reviewed based on the time limits stipulated in the Member’s contract and therefore are determined by the member’s home plan.

**Necessary Information**

Necessary information consists of 1) each applicable date of service; 2) the subscriber or member name; 3) the patient name; 4) the subscriber or member ID number (including alpha prefix); 5) the provider name; 6) the provider tax ID number; 7) the dollar amount in dispute, if applicable; 8) the provider position statement explaining the nature of the dispute; and 9) supporting documentation when necessary, e.g., medical records, proof of timely filing.

**Designating a Provider Representative and Face-to-face Opportunity**

Anthem shall offer the provider the opportunity to designate a provider representative in the dispute resolution process. Anthem shall allow the provider or the provider’s representative the opportunity to present the rationale for the dispute resolution request in person. In cases where the provider determines that a face-to-face meeting is not practical, Anthem shall offer the provider the opportunity to utilize alternative methods such as a teleconference or videoconference to present the rationale for the dispute resolution request. Anthem may require appropriate confidentiality agreements from representatives as a condition to participating in the dispute resolution process. The parties may mutually agree in writing to extend the timeframes beyond the forty-five (45) calendar days from receipt of all necessary information timeframe established by this regulation. National Accounts does not offer a face to face appeals process due to the involvement with multiple state plans.

**Notification Requirements**

For Local provider dispute resolution requests where all necessary information was provided, Anthem shall send written confirmation of receipt within thirty (30) calendar days of the dispute resolution request. The written confirmation must contain:

- A description of the carrier's dispute resolution procedures and timeframes;
- The procedures and timeframes for the provider or the provider's representative to present his rationale for the dispute resolution request; and
- The date by which the carrier must resolve the dispute resolution request.

When the appeal request is resolved in favor of the provider in accordance with this policy within thirty (30) days, the notice of favorable resolution will act as written confirmation.

In cases where the carrier does not receive all necessary information to make a decision, the carrier shall send, within thirty (30) days of receipt of the provider dispute resolution request, a written notice to the provider that must contain:
a. A description of the additional necessary information required to process the request;

b. The date that additional information must be provided by the provider; and

c. A statement that failure to provide the requested information within thirty (30) calendar days from the carrier's request for additional information will result in the closure of the request with no further review.

In cases where the provider does not submit the additional necessary information required by the carrier and the carrier closes the request, the carrier shall notify the provider that the case is closed and that further consideration of the closed dispute resolution request must begin with a new request by the provider.

Anthem shall provide notification of the determination to the provider. In the event the determination is not in favor of the provider, the written notification shall include the principal reasons for the determination. The written notification shall contain:

a. The names and titles of the parties evaluating the provider-carrier dispute resolution request, and where the decision was based on a review of medical documentation, the qualifying credentials of the parties evaluating the provider-carrier dispute resolution request;

b. A statement of the reviewers' understanding of the reason for the provider's dispute;

c. The reviewers' decision in clear terms and the rationale for the carrier's decision; and

d. A reference to the evidence or documentation used as the basis for the decision.

Local providers have a single-step internal dispute resolution's process. Based on the type of issue being appealed, Anthem’s provider advocates and medical directors, its medical review, medical policy and provider contracting departments, and/or other appropriate business areas may review appeal requests.

**Provider Dispute Resolution Form**

This form is available in electronic format for typing your information. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Answers@Anthem tab, select the link titled ‘Download Commonly Requested Forms”, then “Provider Dispute Resolution Form”.

Please use the Provider Dispute Resolution Form, for all provider-carrier appeal requests. Send all requests to:
Member Non-compliance Procedure

If a member refuses treatment that an Anthem Provider or Facility has recommended, the provider may decide that the member’s refusal compromises the provider-patient relationship and obstructs the provision of proper medical care. Providers will try to render all necessary and appropriate professional services according to a member’s wishes when the services are consistent with the provider’s judgment. If a member refuses to follow the recommended treatment or procedure, the member is entitled to see another provider of the same specialty for a second opinion. The member may also pursue the appeal process. If the second provider’s opinion upholds the first provider’s opinion and the member still refuses to follow the recommended treatment, Anthem may then terminate the member’s coverage following thirty (30) calendar days’ notice to the member. If coverage is terminated, neither Anthem nor any provider associated with Anthem will have any further responsibility to provide care to the member.

Anthem may also cancel the coverage of any member who acts in a disruptive manner that prevents the orderly operation of any provider.

Network Adequacy

Anthem has established and monitors network adequacy standards to help ensure that our members have adequate, appropriate and timely access to PCPs (family and general practitioners, internists and pediatricians who have agreed to act as PCPs), high-volume specialists, hospitals and other health care providers. These adequacy standards include the number of providers, the geographic distribution of providers, and timely access for routine, emergency and urgent care conditions.

Nevada Access and Availability Standards

Accessibility - Plan’s members can obtain available services:

- PCP Regular/Routine Care ≤30 days
- PCP Urgent Care within same day or 1 day
- PCP After-Hours Care 24 X 7
• PCP Open Practice
• Member Complaints unavailable to get a timely appointment
• Member Telephone Service
  - Average Speed of Answer
  - Abandonment Rate
• Behavioral Health - After hours, 24/7 Emergency Access:
• Behavioral Health-Emergency, non-LT within 6 hours
• Behavioral Health-Urgent within 48 hours
• Behavioral Health-Routine within 10 working days

**Availability - The extent to which the Plan’s practitioners of the appropriate type and number are distributed geographically to meet the needs of its membership:**

- PCP’s:
  - 20 PCPs/10,000 members

- Specialists:
  - OB/GYN – 2.9 / 10,000
  - Ortho – 0.6 / 10,000
  - Surgery – 0.7 / 10,000
  - Cardiology – 0.5 / 10,000
  - Dermatology – 1 / 8,000
  - Gastroenterology – 1 / 8,000
  - Ophthalmology – 1 / 8,000
  - Psychiatrists – 0.6 / 10,000
  - Non-MD BH – 8 / 10,000

**Availability Geographic Distribution:**

- PCP:
  - Urban - 1 in 25 miles
  - Rural - 2 in 60 miles

- OB-GYN:
  - Urban – 2 in 45 miles
  - Rural – 1 in 100 miles

- Specialist-Medical
  - Urban - 2 in 45 miles
  - Rural – 1 in 100 miles

- Hospitals-Medical
  - Urban - 1 in 25 miles
  - Rural - 1 in 60 miles
• Hospitals-Behavioral Health
  - Urban – 1 in 25 miles
  - Rural – 1 in 45 miles

*Urban or metro is defined as counties having a population of 100,000 or greater.*

**After Hours**

After hours care is provided by physicians who may have a variety of ways of addressing members’ needs. Members should call his/her PCP for instructions on how to receive medical care after the PCP’s normal business hours, on weekends and holidays, or to receive non-Emergency Care and non-Urgent Care within the service area for a condition that is not life threatening but that requires prompt medical attention. In case of an Emergency, the Member should call 911 or go directly to the nearest Emergency room. If he/she is outside the service area, non-emergency Covered Service may be covered under the BlueCard Program.

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**Product Summary**

**Product Summary**

Please see anthem.com for a full listing of Plans and Benefits. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Plans & Benefits tab, select from the following links for additional information:

- Group Health
- Individual Health
- Lumenos Consumer-Driven Health Plans
- Medicare Eligible
- Prescriptions
- Vision
- Anthem Behavioral Health
- Workers’ Compensation
- Employee Assistance Program
- FEP
  - FEP link: Find out important information for all FEP members nationwide from the official FEP website at fepblue.org.
  - FEP Provider Information link: Find out specific provider information regarding the FEP.
- Dental
- Life
Products that Require Separate Agreements

- HMO
- PPO
- Indemnity
- Medicare Advantage
- Workers’ Compensation

Refer to your provider contracting representative or to Anthem’s online provider directory to know if you are in-network for any of the networks listed above.

- If you don’t know who your assigned contracting representative is, please reference the Escalation Contact List. Or go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the link titled Contact Us (Escalation Contact List & Alpha Prefix Reference List).

- For a complete listing of Providers and Facilities, please check our online directory. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Provider Home tab, select the enter button from the blue box on the left side of page titled “Find a Doctor”.

BlueCard Website

Please refer to the BlueCard section online for additional information. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. From the Communications tab, select Publications, then BlueCard Provider Manual. Select the link titled “Section 3 – Products Included in the BlueCard Program”.

Federal Employee Health Benefit Program

Overview

Through the Federal Employee Health Benefits Program (“FEHBP”) aka Federal Employee Program (“FEP”), the federal government contracts with more than two hundred fifty (250) health plans to provide health care coverage for its employees and retirees, including their families. The government-wide FEP is underwritten by the Blue Cross and Blue Shield Association (The Association), which works with the U.S. Office of Personnel Management (“OPM”) and local Blue Cross and/or Blue Shield plans to administer the FEP. The Service Benefit Plan is offered throughout Anthem's service areas. More federal employees and annuitants subscribe to the Blue Cross and Blue Shield Service Benefit Plan nationwide than any other FEP plan.
FEP Program Requirements

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

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

Blue Cross and Blue Shield Association

All Blue Cross and/or Blue Shield plans belong to the Blue Cross and Blue Shield Association. Each participating Blue Cross and/or Blue Shield plan has signed a Plan Participation Agreement with the Association to process claims, with the exception of retail pharmacy claims, and to answer inquiries for the FEP members who reside in the plan’s service areas.

FEP Director’s Office

The FEP Director’s Office is part of the Association and is located in Washington, D.C. The Director’s Office helps plans in a variety of areas, such as interpreting benefits, training, responding to OPM audits, meeting plans’ and national Association performance standards, and providing information to OPM when members appeal a plan’s denial of benefits.

Informational Sources

For information about providers, benefits, dental benefits and FEP pharmacy programs, go to anthem.com, and select the link titled Provider in the upper left corner. Select Nevada from the drop down list and enter. Under the Plans and Benefits tab select from the following FEP links:

- **FEP link**: Find out important information for all FEP members nationwide from the official FEP website at fepblue.org.
- **FEP Provider Information link**: Find out specific provider information regarding FEP.
Medical Management

Anthem Blue Cross and Blue Shield
Federal Employee Health Benefits Program Service Benefit Plans
FEP Medical Management Department
Phone: 800-860-2156   Fax: 800-732-8318

Note: Providers may leave clinical information on FEP’s confidential voice mail system at any time.

Pre-certification Is Required for the Following:

- All inpatient hospital admissions (except maternity admissions for routine delivery)
  - Elective inpatient stays before admission
  - Emergent inpatient stays require notification within two business days.
- Maternity stays exceeding forty-eight (48) hours for vaginal deliveries or ninety-six (96) hours after c-sections
- Infant stays after the mother has been discharged

Note: Failure to pre-certify may result in a financial penalty to the member. No pre-certification is required if Medicare or another payer is the primary payer.

General Guidelines

Most FEP members are responsible for obtaining pre-certification unless otherwise noted in the provider’s Agreement. FEP members should remind their physician or hospital to contact the Anthem.

The FEP medical management department must approve any additional hospital stay days beyond the initial authorization. Any denied request will result in no Anthem payment for inpatient hospital or physician services.

Please direct service requests or questions about outpatient procedures or services to the appropriate provider customer service unit. FEP does not require or perform pre-certification for outpatient services.

Review requests are usually completed within twenty-four (24) hours.

FEP Flexible Benefit Option (Case Management)

FEP provides case management on a voluntary basis to members in need of benefit extensions or benefit flexing. FEP case managers also perform required prior approval for hospice services. Services or procedures that are contract exclusions are not eligible for the flexible benefit option.

Phone: 800-711-2225
Fax: 800-732-8318
HMO Nevada Point-of-Service Rider

HMO Nevada offers employer groups a POS rider designed to complement BlueAdvantage HMO benefits. The POS rider is an “opt-out” product for those members who want to receive covered medical services without guidance from an HMO Nevada PCP.
**In-network (HMO benefits):** A member must select a PCP. If the member follows HMO Nevada guidelines and sees only the selected PCP or seeks services from in-network specialists, the member receives the member’s BlueAdvantage HMO benefits, less any in-network copayments. Emergency benefits are provided through HMO Nevada if the member follows HMO Nevada procedures.

**Out-of-network (POS benefits):** A member can choose to receive medical services from an out-of-network provider. Certain services under the POS provision will be covered at a lower level than services received from the selected PCP or in-network specialists. This means members may have to pay an annual deductible, as well as coinsurance, for these services. The out-of-network provider’s reimbursement for POS services is based on HMO Nevada’s maximum benefit allowance, according to the member’s Health Benefit Plan. Certain services will require pre-certification.

The following services are not covered under HMO Nevada’s POS provisions when rendered by an out-of-network provider, but they may be covered under the HMO provisions when rendered by an in-network PCP or an in-network specialist:

- Ambulance services (except emergency ambulance services)
- Chemical dependency rehabilitation treatments
- Infertility services
- Behavioral health services, except biologically based mental health, i.e., parity, diagnoses (see the Behavioral Health and Substance Abuse Services section for a listing of parity diagnosis codes)
- Preventive care services, except annual gynecological exams, and well-baby and well-child care, up to age thirteen (13)
- Certain organ transplants

**HMO Nevada Away from Home Care® Program**

The Away from Home Care program is part of the program and provides certain benefits to eligible members who are traveling outside their Blue Cross and/or Blue Shield HMO home plan’s service area and staying in the service area of a participating Blue Cross and/or Blue Shield HMO host plan. The benefits provided under the Away from Home Care program are as follows:

- **Emergency care** for unexpected illness or injury that requires immediate medical care
- **Urgent care** for unexpected illness or injury that isn’t life-threatening but that cannot reasonably be postponed until the member returns home. Urgent care includes follow-up to an initial urgent care visit.
- **Pre-certified follow-up care** for an injury or illness that originated in the HMO home plan service area that requires medical care while the member is traveling away from home. This care is pre-arranged by the member with the member’s
home plan before services are rendered. Follow-up care includes, but isn’t limited to, services such as allergy shots, high-blood-pressure checks and cast removal.

Out-of-state Blue Cross and/or Blue Shield HMO plans have elected to use the BlueCard program to process urgent and follow-up care claims. Members of these plans will present their out-of-state member ID card at the time of service. These cards have a three-letter alpha prefix and a suitcase emblem that indicates their eligibility in the BlueCard program. Please collect any applicable copayments as listed on the member’s ID card, and submit claims to the BlueCard address in the Telephone/Address Directory section of this Manual. These claims will be processed and priced according to the Provider or Facility’s HMO Nevada contracted rates.

Local HMO Nevada member ID numbers will contain an YFN or YFY alpha prefix. Claims for HMO Nevada members are processed through the local HMO Nevada claims address listed in the Telephone/Address Directory section of this Manual and not through BlueCard.

The Guest Membership benefit of the Away from Home Care program provides courtesy membership for members who are temporarily residing outside their HMO home plan service area and who are enrolled in the HMO Nevada Guest Membership program. Members receive a courtesy enrollment from the HMO Nevada guest membership department and have access to a comprehensive range of benefits, including routine and preventive care services. Members must complete a guest services application with their HMO home plan and then work with the HMO Nevada guest membership department to select a local PCP. The member pays any applicable copayments and deductibles to the provider at the time of service, and HMO Nevada pays the provider.

BlueCard Member Eligibility

With the member’s current ID card in hand, providers can verify membership and coverage by calling BlueCard eligibility at the phone number in the Telephone/Address Directory section. An operator will ask for the alpha prefix on the member’s ID card and will connect the provider to the appropriate membership and coverage unit at the member’s Blue Cross and Blue Shield plan.

If you’re unable to locate an alpha prefix on the member's ID card, check for a phone number on the back of the ID card. If that’s not available, call the provider customer service phone number in the Alpha Prefix Reference List in the Telephone and Address Directory section of the Manual.
Medicare Advantage

Medicare Advantage Provider Website

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

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

- Medicare Advantage HMO and PPO Provider Guidebook

Audit

Anthem Audit Policy

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

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

Definition:

The following definitions shall apply to this Audit section only:

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

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

  Appeal Response means Anthem’s written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility
• Audit means a qualitative or quantitative review of services or documents relating to such Health Services rendered to be rendered, by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.

• Audit Report and Notice of Overpayment ("Audit Report") means a document that constitutes notice to the Provider or Facility that Anthem believes an overpayment has been made by Anthem identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit that constitute the basis for Anthem’s belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.

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

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

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

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

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

Procedure:

1. Review of Documents. Plan or its designee will request in writing or verbally, final and complete itemized bills for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Plan within thirty (30) calendar days of Plan’s request.
2. **Scheduling of Audit.** After review of the documents submitted, if Plan determines an Audit is required, Plan will call the Provider or Facility to request a mutually satisfactory time for Plan to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.

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

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

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

6. **On-Site and Desk Audits.** Plan may conduct Audits from its offices or on-site at the Provider’s or Facility’s location. If Plan conducts an Audit at a Provider’s or Facility’s location, Provider or Facility will make available suitable work space for Plan’s on-site Audit activities. During the Audit, Plan will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed member authorization. When conducting credit balance reviews, Provider or Facility will give Plan or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Plan or its designee will have complete access to Provider’s or Facility’s patient accounting system to review payment history, explanation of benefits (EOB), notes and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Plan access to the items requested to complete the Audit, Plan may opt to complete the Audit based on the information available. All Audits shall be conducted free of charge despite any Provider or Facility policy to the contrary.
7. **Completion of Audit.** Upon completion of the Audit, Plan will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Plan will discuss with Provider or Facility, its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Plan, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Plan the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation, or Appeal the Audit findings.

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

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

**Documents Reviewed During an Audit:**

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

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

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

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

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

Audit Appeal Policy

Purpose:

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

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

Procedure:

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

2. A Provider’s or Facility’s written request for an extension to submit an Appeal
complete with Supporting Documentation or payment will be reviewed by Anthem
on a case-by-case basis. If the Provider or Facility chooses to request an Appeal
extension, the request should be submitted in writing within thirty (30) calendar
days of receipt of the Audit Report or within thirty (30) calendar days of the
receipt of Anthem’s appeal response and submitted to the Appeals coordinator
identified within the Audit Report. One Appeal extension may be granted during
the Appeal process at Anthem’s sole discretion, for up to thirty (30) calendar
days from the date the Appeal would otherwise have been due. A written
notification of approval or denial of an Appeal extension will be mailed to the
Provider or Facility within seven (7) calendar days. Any extension of the Appeal
timeframes contained in this Policy shall be expressly conditioned upon the
Provider’s or Facility’s agreement to waive the requirements of any applicable
state prompt pay statute and/or provision in an Agreement which limits the
timeframe by which a Recoupment must be completed. It is recognized that
governmental regulators are not obligated to the waiver.

3. Upon receipt of a timely Appeal, complete with Supporting Documentation as
required under this Policy, Anthem shall issue an Appeal Response to the
Provider or Facility. Anthem’s response shall address each matter contained in
the Provider’s or Facility’s Appeal. If appropriate, Anthem’s Appeal Response will
indicate what adjustments, if any, shall be made to the overpayment amounts
outlined in the Audit Report. Anthem’s response shall be sent via certified mail to
the Provider or Facility within sixty (60) calendar days of the date Anthem
received the Provider’s or Facility’s Appeal and Supporting Documentation.
Revisions to the Audit data will be included in this mailing if applicable.

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

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

6. If applicable in the state, the Provider or Facility shall have thirty (30) calendar days from the date of Anthem’s final Appeal Response to send a remittance check to Anthem. If no remittance check is received within the thirty (30) day timeframe, Anthem shall recoup the amount contained in Anthem’s final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.

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

Laboratory Services

Laboratory Procedures

Anthem is contracted with Laboratory Corporation of America® (“LabCorp”). All lab work, including Pap tests and routine outpatient pathology, must be sent to LabCorp, with the exception of the procedures listed below that can be performed in the Provider’s office or sent to LabCorp:

Note: This relationship with LabCorp is specific to national reference lab services and does not affect network hospital-based lab service providers, contracted pathologists, or independent laboratories.

<table>
<thead>
<tr>
<th>Lab Work that can be provided in the Provider’s Office</th>
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<tbody>
<tr>
<td><strong>HCPCS</strong></td>
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<tr>
<td>80048</td>
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### Lab Work that can be provided in the Provider’s Office

<table>
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<tr>
<th>HCPCS</th>
<th>Description</th>
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<th>Description</th>
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<tbody>
<tr>
<td>81015</td>
<td>Microscopic exam of urine</td>
<td>87220</td>
<td>Tissue exam for fungi</td>
</tr>
<tr>
<td>81025</td>
<td>Urine pregnancy test</td>
<td>87430</td>
<td>Strep a ag, eia (Rapid Strep)</td>
</tr>
<tr>
<td>82120</td>
<td>Amines, vaginal fluid, qualitative</td>
<td>87802</td>
<td>Infectious agent antigen detection by immunoassay with direct optical observation; Streptococcus, group B</td>
</tr>
<tr>
<td>82270</td>
<td>Occult blood, feces</td>
<td>87804</td>
<td>Influenza assay w/optic</td>
</tr>
<tr>
<td>82271</td>
<td>Occult blood, other sources</td>
<td>87807</td>
<td>Rsv assay w/optic</td>
</tr>
<tr>
<td>82803</td>
<td>Gases, blood, any combination of pH, pCO2, P2, CO2, HC03 (including calculated O2 saturation). This procedure approved for Pulmonologists ONLY.</td>
<td>87880</td>
<td>Strep a assay w/optic</td>
</tr>
<tr>
<td>82947</td>
<td>Glucose; quantitative (except reagent strip)</td>
<td>89260</td>
<td>Sperm isolation; simple prep (e.g., sperm wash and swim-up) for insemination or diagnosis with semen analysis.</td>
</tr>
<tr>
<td>82948</td>
<td>Glucose; blood reagent strip</td>
<td>89261</td>
<td>Sperm isolation; complex prep (e.g., Percoll gradient, albumin gradient) for insemination or diagnosis with semen analysis</td>
</tr>
<tr>
<td>82962</td>
<td>Glucose; blood by glucose monitoring device(s) cleared by the FDA specifically for home use.</td>
<td>89300</td>
<td>Semen analysis w/huhner</td>
</tr>
<tr>
<td>85002</td>
<td>Bleeding time</td>
<td>89310</td>
<td>Semen analysis w/count</td>
</tr>
<tr>
<td>85007</td>
<td>Blood count; blood smear, microscopic examination with manual differential WBC count</td>
<td>89320</td>
<td>Semen analysis, complete</td>
</tr>
<tr>
<td>85013</td>
<td>Spun microhematocrit</td>
<td>89321</td>
<td>Semen analysis &amp; motility</td>
</tr>
<tr>
<td>85014</td>
<td>Hematocrit</td>
<td>89330</td>
<td>Sperm evaluation; cervical mucus penetration test, with or without spinnbarkeit test</td>
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<tr>
<td>85018</td>
<td>Hemoglobin</td>
<td>G0027</td>
<td>Semen analysis</td>
</tr>
<tr>
<td>85025</td>
<td>Complete CBC w/auto diff</td>
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Lab work that can be provided in the Provider’s Office

<table>
<thead>
<tr>
<th>HCPCS</th>
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<tr>
<td>WBC</td>
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<tr>
<td>85610</td>
<td>Prothrombin time</td>
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Lab procedure codes for procedures that can be performed at the physician’s office can be billed as fee-for-service. Codes on this list are not a guarantee of payment. Coverage may be restricted by member benefits.

Venipuncture and blood collection services:

- Effective January 1, 2010, codes 36415 venipuncture, and/or 36416, collection of capillary blood specimen (e.g., finger, heel, or ear stick) are allowed in addition to the lab and/or the E/M code. (Only one of these codes should be reported per visit).
- Per the parenthetical guidelines in CPT® 2010 and 2011, the AMA has changed their position on how codes 36591, Collection of blood specimen from a completely implantable venous access device and 36592, Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified, should be processed.
- Please refer to Reimbursement Policy Laboratory and Venipuncture Services for implementation dates for ClaimsXten editing for these services.

Code 99000, handling or conveyance of a specimen, is on Reimbursement Policy: Bundled Services and Supplies and is considered part of the overall medical management of the patient and is not reimbursed separately.

Reviewing results of laboratory tests, phoning results to patients, filing such results, etc., are included in Anthem’s allowance for the E/M code, even if the E/M code is not on the same day.

A charge related to drawing of blood performed by an OB/GYN is payable as a separate service and isn’t included in the total obstetrical allowance if the blood is sent to the lab.

An appropriate diagnosis to justify the procedure must accompany all lab procedures.

Specimen collections: For specimen requirements for various lab tests, collection procedures, specimen preparations and submission protocols, please call LabCorp at 303-792-2600 or toll free at 800-795-3699. Instructions for certain labile specimens are as follows:

- Routine pediatric specimen collections can be performed at the drawing stations of the independent laboratories contracted with Anthem.
• **Stat:** If an emergency situation exists and you can’t wait for LabCorp’s stat turnaround (three to four hours from the time the lab is called), you can mark “STAT” on your claim form for that lab procedure. However, Anthem will pay the lab charge only and will not pay for “STAT” fee charges.

• If the original claim doesn’t denote “STAT” and is denied for payment because it should have been sent to LabCorp, Anthem will not pay at a later date even if the claim is resubmitted with “STAT” marked on it.

• **Cerebrospinal fluid/bone marrow aspirate:** Due to the labile nature of these specimens, Anthem recommends that they be transported to the nearest hospital for analysis. Please call LabCorp for information or instructions. This also helps with reporting results properly and obtaining written copies of the results.

• **Non-gynecologic cytology:** Place specimens such as urine, bladder washing, body fluids (peritoneal, gastric), cyst fluids and cerebrospinal fluids in a clean, leak-proof container with an equal volume of fifty percent (50%) alcohol.

• **Histology:** Place tissue in leak-proof biopsy bottles containing ten percent (10%) formalin in a volume five (5) times that of the specimen. Do not use a preservative if microbiological cultures are required.

LabCorp will contact providers if it receives inadequate, inappropriate, or improperly prepared or stored specimens.

**Other Considerations**

A physician or other health care provider may not bill for services sent to an outside lab. This includes cytopathology services for cervical cancer screening (Pap codes 88141-88175 and P3000-P3001). Codes 88141-88175 and P3000-P3001 are to be used by the laboratory performing the test, not by the physician obtaining the specimen. Effective with ClaimsXten implementation on November 14, 2009, Pap smear codes are now denied when reported with E/M codes.

Q0091-Obtaining the specimen for cervical cancer screening is included in the allowance for and is thus incidental to the E/M or the preventive care visit service and is not reimbursed separately.

**Specialized Anatomic Pathology**

LabCorp is a leader in innovative diagnostic testing, with active research and development groups. Some of its specialized services include the following:

• A.P. triple screens
• AIDS-related testing, including genotype and phenotype analysis
• Allergy (RAST and Imunocap) testing
• Genetic/cytogenetic testing with board-certified cytogeneticists and genetic counselors available for consultation
- Tumor marker testing
- DNA probe testing

For information about specialized assays or about requirements for special collection kits and specimen handling, call LabCorp at 303-792-2600 or toll free at 888-LABCORP (888-522-2677).

LabCorp Patient Service Centers

To find a LabCorp location near you, go to www.LabCorp.com or call one of the phone numbers above.

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Pharmacy Services

The information in this section applies to Anthem members with our prescription drug coverage.

Prescription Drug Benefit Design

Anthem has various prescription drug benefit designs. A member’s cost is typically lower for a generic drug than for a brand-name medication.

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<thead>
<tr>
<th>Drug Category</th>
<th>Member Copayment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic X on formulary (tier 1)</td>
<td><strong>Tier-1</strong> - means a drug that has the lowest Copayment. This tier has low cost or preferred medications. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.</td>
</tr>
<tr>
<td>Brand A formulary – no generic equivalent available (tier 2)</td>
<td><strong>Tier-2</strong> - means a drug that has a higher Copayment than those in tier 1. This tier has preferred medications that generally are moderate in cost. This tier may include Generic Drugs, Single Source Drugs and Multi-Source Drugs.</td>
</tr>
<tr>
<td>Brand C non-formulary – no generic equivalent available (tier 3)</td>
<td><strong>Tier-3</strong> - means a drug that has a higher Copayment than those on tier 2. This tier may have non-preferred medications which are generally higher in cost. This tier may include Generic Drugs, Single Source Drugs,</td>
</tr>
<tr>
<td>Drug Category</td>
<td>Member Copayment</td>
</tr>
<tr>
<td>--------------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Brand D non-formulary (tier 3) – generic equivalent available (tier 1)</td>
<td>Tier-3 - means a drug that has a higher Copayment than those on tier 2. This tier may have non-preferred medications which are generally higher in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs. + difference in cost between the brand and its generic equivalent + applicable copay</td>
</tr>
<tr>
<td>Tier 4</td>
<td>Tier-4 - means drugs with the highest Copayment. This tier has medications which are generally highest in cost. This tier may include Generic Drugs, Single Source Drugs, and Multi-Source Drugs.</td>
</tr>
<tr>
<td>Benefit exclusion examples: Some drugs, such as over-the-counter agents, sexual dysfunction agents, those used for cosmetic purposes, or Prescription Drugs that have a Clinically Equivalent alternative, even if written as a prescription.</td>
<td>Full cost of drug</td>
</tr>
</tbody>
</table>

For more formulary/drug list information is available online. Please go to the following link on the Anthem provider Portal, under forms: [http://www.anthem.com/health-insurance/customer-care/forms-library](http://www.anthem.com/health-insurance/customer-care/forms-library). You can also download information and updates to a handheld Palm Pilot at [www.ePocrates.com](http://www.ePocrates.com).

**Tier 4 Medications**

Tier 4 medications must be obtained through the Anthem pharmacy network. The list of four-tier medications can be located online at Anthem.com. Please go to the following link on the Anthem provider Portal, under forms: [http://www.anthem.com/health-insurance/customer-care/forms-library](http://www.anthem.com/health-insurance/customer-care/forms-library).

The list of fourTier 4 medications is subject to change.

**Pharmacy Benefit Drugs Requiring Authorization**

Anthem’s Pharmacy Benefit Manager is committed to helping Anthem’s members manage their health care benefits. Prior authorization, quantity limits, step therapy and dose optimization are edits approved by Anthem’s National Pharmacy and Therapeutics.
committee. These edits help ensure that members’ benefits provide them with access to safe, appropriate and effective medications.

- **Prior authorization** may require a member to obtain approval before receiving benefits to cover the medication.

- **Step therapy** may require a member to use another type of medication first before receiving benefits for another medication.

- **Quantity limits** may affect the quantity of a certain medication a member can receive benefits for each month.

- **Dose optimization** (or dose consolidation) usually involves converting from a twice-daily dosing schedule to a once-daily dosing schedule. A once-daily dosing schedule may increase compliance and decrease expenses for the member and Anthem.

To request a prior authorization for a drug, please call the pharmacy prior authorization help desk at 866-310-3666.

A complete list of medications and prior authorization forms can be found at the following link via the Anthem.com provider website. [http://www.anthem.com/pharmacyinformation/priorauth.html](http://www.anthem.com/pharmacyinformation/priorauth.html)

**Clinically Equivalent Medications Program**

**Our insured business and a number of our other health plan clients no longer cover certain medications.** We have begun excluding coverage for certain prescription drugs within a therapeutic class that don’t provide the best value and which may have over-the-counter options available, and including coverage for less costly, clinically equivalent alternatives. For a complete list of medications under this program, please go to our forms library at the following link, [http://www.anthem.com/health-insurance/customer-care/forms-library](http://www.anthem.com/health-insurance/customer-care/forms-library).

**GenericSelect Program**

**GenericSelect** allows current Anthem members to receive their first prescription of a select generic drug for no co-payment. The customer may have **one (1) co-payment waived at mail and/or retail**. This is a voluntary program. A list of current medications in the program can be obtained by calling the customer service department on the back of the member’s health plan ID card. The retail portion of this program is available to all customers who are first time users of the selected generic medication. Customers can receive **one (1) thirty (30) day supply** of the same select generic medications at the retail pharmacy with the first co-payment waived. The mail program allows customers currently receiving a targeted brand medication to receive **one (1) ninety (90) day supply** of the select generic through the mail for no co-payment. Additional fills will be
charged any applicable copayment. For a complete list of medications under this program, please go to out forms library at the following link, 

Half-Tab Program

Anthem’s Pharmacy Benefit Manager Half Tablet Program is designed to help customers save up to fifty percent (50%) on out-of-pocket costs for select medications by splitting tablets in half. Customers who participate in this voluntary program can expect to save immediately by either reducing their copayment or reducing their portion of coinsurance paid. This is a voluntary program and tablet splitters are provided. A list of current medications in the program can be obtained by calling the customer service department on the back of the member’s health plan ID card. For a complete list of medications under this program, please go to out forms library at the following link, 

Home Delivery Pharmacy Program

Anthem members can enroll in and use the Home Delivery Pharmacy program for up to a ninety (90) day supply of maintenance medications, used to treat chronic health conditions. With many Anthem prescription drug plans, our members usually have reduced copayments and can save money by using home delivery pharmacy. More information about the home delivery pharmacy program is available online. Please go to the following link on the Anthem website, under the forms library: 

For new prescriptions, please order the "retail" quantity of no more than a thirty (30) day supply to minimize waste if the drug or dose needs to be changed, and then order a ninety (90) day supply via home delivery pharmacy once it's medically appropriate.

Specialty Pharmacy Services

Anthem’s contracted Specialty Pharmacy is Anthem’s preferred source for specialty prescription medications. For more information about specialty medications, please call 877-500-3701 toll free, or go to online to view the current specialty drug list. Please go to the following link on the Anthem website, under the forms library: 

We encourage you to use Anthem’s Specialty Pharmacy to fill specialty prescriptions for your Anthem patients. It is a full-service specialty pharmacy that delivers specialty drugs to more than one (1) million people nationwide and provides case management services to patients taking specialty medications. Most Anthem prescription benefit plans now require certain specialty medications be filled only by Anthem’s Specialty Pharmacy.
Anthem’s Specialty Pharmacy offers you and our members these personalized services and resources:

- A team of nurses, pharmacists and care coordinators who offer personal support related to the member’s specialty medications and associated health care concerns
- Care coordinators who remind patients when it’s time to refill their prescriptions and who’ll coordinate delivery as requested
- A clinical case management team that understands our members’ needs and can provide helpful information about their condition to support your treatment plan

To use Anthem’s Specialty Pharmacy to fill specialty medications for your Anthem patients, you have two options:

1. **Call toll free at 877-500-3701.** A care coordinator will get the information that’s needed to begin the prescription process. Care coordinators are available **from 6 a.m.-7 p.m. Mountain Time, Monday through Friday.** For TDD/TTY assistance, our members can call 800-221-6915 toll free from 6:30 a.m.-3 p.m. Mountain Time, Monday through Friday.

2. **Fax the prescription and a copy of the member’s health plan ID card to Anthem’s Specialty Pharmacy toll free at 800-824-2642.**

**Pharmacy Benefit Management and Drug List/Formulary**

Anthem’s Pharmacy and Therapeutics Committee consists of two interdependent subcommittees – the Clinical Review Committee and the Value Assessment Committee. Together, the subcommittees work as a checks-and-balances system, helping to maintain a clinically based drug list/formulary that offer’s our members access to quality, affordable medications.

**Clinical Review Committee (“CRC”):** The CRC assigns clinical designations to medications. The designations are determined through review of current guidelines and treatment criteria from sources like major medical publications, professional journals, medical specialists, product package inserts, etc.

**Value Assessment Committee (“VAC”):** The VAC meets after the CRC has established the clinical foundation and rationale. Its role is to determine tier assignments, or coverage levels, for medications. To help ensure clinical guidelines are properly balanced with financial considerations, the VAC must take into account the CRC’s clinical designations when recommending medications for the Anthem national drug list/formulary. In addition to the designations assigned by the CRC, the VAC may also look at financial information (i.e., average wholesale price, rebates, ingredient cost, cost of care, copayments and coinsurance), market factors and the impact on members to determine tiers/levels. The VAC is responsible for creating tier assignments that appropriately balance the impact on clinical, financial and member considerations.
Additions to the Anthem drug list/formulary currently occur four (4) times a year. Formulary deletions can occur at least twice a year. For Anthem members to receive their highest level of benefits, all Providers and Facilities should use the drug list/formulary when prescribing medications. A copy of the drug list/formulary is available online. Go to the following link, [http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f3/s3/t0/pw_ad071376.htm&rootLevel=2&state=co&label=Prescription](http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/co/f3/s3/t0/pw_ad071376.htm&rootLevel=2&state=co&label=Prescription). You can also download information and updates to a handheld Palm Pilot at [www.ePocrates.com](http://www.ePocrates.com).

To request addition of a medication to the Anthem drug list/formulary, please access the Drug List/Formulary online as indicated above, and select the following link [http://www.anthem.com/forms/pharmacy/formulary_addition.html](http://www.anthem.com/forms/pharmacy/formulary_addition.html).

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**Behavioral Health and Chemical Dependency Rehabilitation Services**

Anthem’s behavioral health operations acts as a facilitator for directing members to behavioral health and chemical dependency rehabilitation services and managing member care in accordance with the member’s needs, location and Health Benefit Plan coverage. Providers may refer members to Anthem’s behavioral health operations (although a referral isn’t required) at the numbers listed below to locate a Provider or Facility for behavioral health and chemical dependency rehabilitation services:

- All Local Plan members: 866-621-0043
  - Local Plan members are defined by referencing the [Alpha Prefix Reference List](#).
- FEP members: 800-424-4011
  - FEP members are identified by the following alpha prefix:
    - R + 8 numerics

**Please note:** Anthem’s behavioral health operations doesn’t manage behavioral health and chemical dependency rehabilitation services for BlueCard and national account members. For those members, please refer to the behavioral health/substance abuse phone number on the back of the member’s health plan ID card.

In emergency situations, please call 911 or direct the member to the nearest emergency facility. Anthem’s behavioral health operations will also be available to direct you and the member to an appropriate facility or other provider for emergency services.

**Authorizations**

For behavioral health services that require authorizations, please see the Quick Reference Pre-certification Guide in the Referrals and Pre-certifications section of this Manual.
Psychotherapy Notes Authorization

Complete this form for release of psychotherapy notes from provider to Company. If member wishes to disclose clinical information and psychotherapy notes, member must complete both the Individual Authorization Form and Psychotherapy Notes Authorization.

Please find the most current copy of the Psychotherapy Notes Authorization form located online at anthem.com:

- Go to anthem.com. Select Provider, Nevada and enter. From the Answers@Anthem tab, select Download Forms, and then select the link titled “Psychotherapy Notes Authorization”.

Individual Authorization Form

Complete this form for release of PHI and clinical information from provider to Company. If member wishes to disclose clinical information and psychotherapy notes, member must complete both the Individual Authorization Form and Psychotherapy Notes Authorization Form.

Please find the most current copy of the Individual Authorization Form located online at anthem.com:

- Go to anthem.com. Select Provider, Nevada and enter. From the Answers@Anthem tab, select Download Forms, and then select the link titled “Individual Authorization Form”.

Detoxification

Detoxification services that can be appropriately managed in a behavioral health care substance abuse unit (the majority of all detoxification services) will be transferred to behavioral health care detoxification units and managed by Anthem’s behavioral health operations. Anthem medical management will manage acute detoxification cases that require acute medical beds based on co-morbid medical conditions such as severe cardiac arrhythmia, septicemia, electrolyte imbalance, GI bleeds, liver failure, diabetic coma, or other severe co-morbid condition.

Utilization Management

- Facility utilization review representatives or intake representatives will transfer detoxification cases to behavioral health care units, and they’ll contact Anthem’s behavioral health operations UM department at 866-621-0043 for pre-certification.
- For acute medical situations that require admission to an acute medical bed detoxification unit, facility utilization review representatives will continue to call Anthem medical management at 800-336-7767 or 702-228-1277.

- **Note:** FEP UM, available toll free at 800-424-4011, will continue to manage detoxification services for all FEP members.

### Anthem Behavioral Health Contact Information

<table>
<thead>
<tr>
<th>Product Name</th>
<th>Reason for Call</th>
<th>Phone Numbers</th>
<th>Claims Submission Address</th>
<th>Alpha Prefix on Member ID Card</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anthem Blue Cross and Blue Shield (local PPO)</strong> M-F: 8 a.m.-noon, 1-4:30 p.m. Authorization not required for outpatient services</td>
<td>Customer service</td>
<td>866-621-0043</td>
<td>877-833-5742</td>
<td>PPO local:BAD, BJZ, EQC, KDQ, KDY, KZQ, KZV, LQP, NWD, NXV, RAR, UKF, UWJ, WOS, WRZ, YFJ, YFK, YFL, YFP, YFT, YFU, YFW</td>
</tr>
<tr>
<td><strong>BlueCard® (out-of-state PPO)</strong> M-F: 8 a.m.-noon, 1-4:30 p.m. Authorization not required for outpatient services</td>
<td>Customer service/claims</td>
<td>888-817-3717</td>
<td>800-676-BLUE (2583)</td>
<td>PPO: all other alpha prefixes not listed with other products</td>
</tr>
<tr>
<td><strong>HMO Nevada</strong> M-F: 8 a.m.-5 p.m. Authorization required for first outpatient visit</td>
<td>Customer service/authorization</td>
<td>866-621-0043</td>
<td>877-833-5742</td>
<td>HMO:YFF, YFN, YFY</td>
</tr>
</tbody>
</table>
| **FEP** M-F: 8 a.m.-5 p.m.  
- **FEP Standard** Authorization required after eighth outpatient visit 
- **FEP Basic** Authorization required for first outpatient visit | Customer service/authorization | 800-424-4011 | 800-727-4060 | R + 8 numerics |

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Workers’ Compensation Program

Workers’ Compensation

Workers’ compensation coverage is based on the philosophy that employers should provide employees with injury protection as a cost of doing business, and that benefits should be provided without regard to the at-fault party when an injury occurs during the course of employment. Anthem has created a network that will join together a group of health care professionals to provide medical care to injured workers. This approach allows employees and members to essentially use the same network for both occupational and non-occupational treatment. Anthem’s workers’ compensation services unit will provide network access, bill review, case management and utilization review services to insurance companies, third-party administrators (“TPAs”) and self-insured employers in Nevada. This can help employers control the health care costs of an injured worker’s claim. If you participate in this network, injured workers will be channeled to you for treatment via referrals from our contracted ancillary networks or claims examiners.

At this time, the network only includes the Las Vegas area, Reno/Sparks and Carson City.

Provider Guidelines

The provider should question a member seeking medical treatment when the nature of the illness or injury appears to be work-related. Some employers insist that all workers’ compensation cases be handled through their private workers’ compensation physicians and only when authorized; these employers won’t reimburse any other physician, hospital, facility or other health care professional service. The provider should determine whether the member’s illness or injury is:

- A non-emergency. Instruct the member to get authorization from the employer before providing treatment.
- An emergency. If a member requires emergency treatment, care must be provided to the injured person. Determining workers’ compensation coverage should be made within the next seventy-two (72) hours. The provider can then collect from the workers’ compensation insurance carrier.

If a member is covered for workers’ compensation benefits by a participating workers’ compensation carrier permissibly, or if a self-insured employer contracting with Anthem seeks services for a work-related illness or injury, the provider has the following options:

1) provide such Medically Necessary medical services, or
2) refer the member to a health care professional that participates in the Anthem occupational medicine network. If the provider elects to treat the member, the
provider must complete a Doctors First Report of Injury, as defined in Nevada Administrative Code 616A – Industrial Insurance Administration.

As payment for the medical services rendered, the provider agrees to accept, as payment in full, compensation in accordance with the reimbursement set forth in the Agreement.

Send all workers’ compensation-related correspondence to:

Anthem Blue Cross and Blue Shield – WCS for Nevada
2170 Towne Center Drive, Suite 320
Anaheim, CA 92806

You can reach customer service for bill review at 800-422-7334 and select option #2. Hours of operation are 8 a.m. to 5 p.m. Pacific Time. Voice mail is available if you call this number after hours.

Utilization Management Guidelines

The utilization management guidelines are those set by Nevada Administrative Code 616A – Industrial Insurance Administration. If you have questions about these guidelines, please contact the Workers Compensation Division. If you have questions about the utilization management process, please call us at 800-422-7334.

Nevada Administrative Code 616A – Industrial Insurance Administration Standards

Nevada Administrative Code 616A – Industrial Insurance Administration has established standards for injured workers for accessing care and guidelines to improve the quality of medical care for occupational injuries. Providers and Facilities must adhere to the following guidelines:

- Maintain medical control for the life of the claim.
- Make referrals within the participating and PPO occupational medicine network. To find providers in the network, call 800-422-7334.
- Services obtained outside the network may not be paid. Contact the claims adjuster for authorization for any medical care outside the network.
- After the initial visit, the injured worker can change to any physician of his/her choice within the network.
- Submit claims to the appropriate workers’ compensation administrator as soon as possible after providing health care services. The Explanation of Review will indicate that rates are in accordance with your Anthem Agreement.
- Prohibit any surcharges or other billings in violation of the Labor Code for workers’ compensation health care services.
The claims administrator will ensure payment for authorized medical services rendered while a claim is under investigation, until such time as a denial of the claim is made by the claims administrator.

Anthem Workers’ Compensation Payers Accessing the Participating and PPO Occupational Medicine Network

For the most current list of participating payers, go to anthem.com, click Plans and Benefits, and select the Workers’ Compensation tab. We'll update this online list monthly, by the fifth of each month.

Rules for Calculating Permanent Disability

The calculation of permanent disability is to be in accordance with the AMA Guides to the Evaluation of Permanent Impairment, 5th Edition. You can get Information about this guideline at www.ama-assn.org.

If you feel you're unable to write the permanent and stationary report, contact the claims examiner to refer the patient to another physician to prepare a report utilizing the guideline.

Grievances

A complaint and grievance process is available. Please call 800-422-7334 for more information.

Additional Information

For more information about the obligations of the treating physician for workers' compensation, go to the Nevada Division of Industrial Relations website at http://dirweb.state.nv.us/ or call us at 800-422-7334.

Glossary

Admission Notification – Notice to the health plan about an urgent or emergent (unscheduled) admission

Alpha Prefix – The three characters preceding the subscriber ID number on Blue Cross and/or Blue Shield health plan ID cards. The alpha prefix is required for system-wide claims routing and identifies the member’s Blue Cross and/or Blue Shield plan or national account.

anthem.com – Anthem’s website, where the Provider Policy and Procedure Manual can be viewed online
Authorization – Approval of benefits for a member’s covered procedure or service

Away from Home Care® Program – Provides HMO members with health insurance coverage for urgent and emergent (life-threatening) medical services when an unforeseen illness or injury occurs while they’re away from their Blue Cross and/or Blue Shield HMO plan’s service area.

Away from Home Care Program Guest Membership Benefit – Health insurance coverage for HMO members from other Blue Cross and/or Blue Shield plans who are staying in Nevada temporarily (but more than three months). This coverage is available through HMO Nevada, and guest membership coverage is based on BlueAdvantage HMO guidelines and benefits.

bcbs.com – The Blue Cross and Blue Shield website, which providers and members can use to locate Providers or Facilities with any Blue Cross and/or Blue Shield plan. This website is useful when a provider needs to refer a member to a provider in another location.

BlueCard Access – A toll-free telephone number, 800-810-BLUE (2583), Providers and members can call to locate providers contracted with any Blue Cross and/or Blue Shield plan. This number is useful when a provider needs to refer a member to a provider in another location.

BlueCard Eligibility – A toll-free telephone number, 800-676-BLUE (2583), Providers can call to verify membership and coverage information for members from other Blue Cross and/or Blue Shield plans.

BlueCard HMO – An out-of-area program available to members of Blue Cross and/or Blue Shield plan-sponsored HMOs. This program provides for urgent, emergent and pre-certified follow-up care.

BlueCard PPO – A national program that offers PPO-level benefits to members traveling or living outside their Blue Cross and/or Blue Shield plan’s service area. They must obtain the services from a physician or hospital designated as a BlueCard PPO Provider.

BlueCard PPO Member – Members whose health plan ID card contains the “PPO in a suitcase” identifier. Only members with this identifier can access BlueCard PPO benefits.

BlueCard Program – A national program that provides members with access to BlueCard providers and savings. The program enables members to obtain health care services while traveling or living in another Blue Cross and/or Blue Shield plan’s area and to receive the same benefits as those under their contracting Blue Cross and/or Blue Shield plan. The program links participating health care providers and the independent Blue Cross and/or Blue Shield plans across the country through a single electronic network for claims processing and reimbursement. The program allows
providers to submit claims for BlueCard members, including those located outside the United States, directly to the provider's local Blue Cross and/or Blue Shield plan.

**BlueCard Provider Finder Website (www.bcbs.com)** – A website providers and members can use to locate Providers and Facilities with any Blue Cross and/or Blue Shield plan. This website is useful when a provider needs to refer a member to a provider in another location.

**BlueCard Worldwide®** – A program that allows Blue Cross and/or Blue Shield members traveling or living outside the United States to receive inpatient, outpatient and professional services from Providers and Facilities worldwide. The program also allows members of international Blue Cross and/or Blue Shield plans to access Blue Cross and/or Blue Shield provider networks in the United States.

**Clinical Guideline** – Clinical Guidelines serve as one of the sets of guidelines for coverage decisions. These guidelines address the Medical Necessity of existing, generally accepted services, technologies and drugs. Because local practice patterns, claims systems and benefit designs vary, a local plan may choose whether to implement a particular clinical UM guideline.

**Concurrent Review** – Conducted to monitor ongoing care in an institutional setting to determine if clinical services and treatment plans continue to meet guidelines for the level of care the member is receiving.

**Contractual Adjustment** – Any portion of a charge for a covered service that exceeds Anthem’s contracted allowed amount/maximum benefit allowance. Providers can’t charge contractual adjustments to members or to Anthem.

**Coordination of Benefits (“COB”)** – A stipulation in most health insurance policies that helps prevent duplicate payments for services covered by more than one insurance policy or program. The COB stipulation outlines which insurance organization has primary responsibility for payment and which insurance organization has secondary responsibility for payment.

**Electronic Data Interchange (“EDI”)** – The computer-application-to-computer-application exchange of business information in a standard electronic format. Translation software aids in exchange by converting data extracted from the application database into standard EDI format for transmission to one or more trading partners.

**Exclusive Provider Organization (“EPO”)** – A more rigid type of Health Maintenance Organization (HMO) health benefit program that provides benefits only if care is rendered by providers who belong to an identified network.

**Experimental/Investigational** –
(a) Any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply used in or directly related to the diagnosis,
evaluation or treatment of a disease, injury, illness or other health condition which we determine in our sole discretion to be experimental or investigational.

We will deem any drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply to be experimental or investigational if we determine that one or more of the following criteria apply when the service is rendered with respect to the use for which benefits are sought.

The drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply:

- Cannot be legally marketed in the United States without the final approval of the Food and Drug Administration (“FDA”) or any other state or federal regulatory agency, and such final approval has not been granted
- Has been determined by the FDA to be contraindicated for the specific use
- Is provided as part of a clinical research protocol or clinical trial, or is provided in any other manner that is intended to evaluate the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply; or is subject to review and approval of an Institutional Review Board (“IRB”) or other body serving a similar function
- Is provided pursuant to informed consent documents that describe the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply as experimental or investigational, or otherwise indicate that the safety, toxicity or efficacy of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is under evaluation

(b) Any service not deemed experimental or investigational based on the criteria in subsection (a) may still be deemed to be experimental or investigational by us. In determining whether a service is experimental or investigational, we will consider the information described in subsection (c) and assess all of the following:

- Whether the scientific evidence is conclusory concerning the effect of the service on health outcomes
- Whether the evidence demonstrates that the service improves the net health outcomes of the total population for whom the service might be proposed as any established alternatives
- Whether the evidence demonstrates the service has been shown to improve the net health outcomes of the total population for whom the
service might be proposed under the usual conditions of medical practice outside clinical investigatory settings

(c) The information we consider or evaluate to determine whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational under subsections (a) and (b) may include one or more items from the following list, which is not all-inclusive:

- Randomized, controlled, clinical trials published in authoritative, peer-reviewed United States medical or scientific journal
- Evaluations of national medical associations, consensus panels and other technology evaluation bodies
- Documents issued by and/or filed with the FDA or other federal, state or local agency with the authority to approve, regulate or investigate the use of the drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Documents of an IRB or other similar body performing substantially the same function
- Consent documentation(s) used by the treating physicians, other medical professionals or facilities, or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- The written protocol(s) used by the treating physicians, other medical professionals or facilities or by other treating physicians, other medical professionals or facilities studying substantially the same drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply
- Medical records
- The opinions of consulting providers and other experts in the field

(d) We have the sole authority and discretion to identify and weigh all information and determine all questions pertaining to whether a drug, biologic, device, diagnostic, product, equipment, procedure, treatment, service or supply is experimental or investigational.

Health Benefit Plan – The document(s) describing the partially or wholly insured, underwritten and/or administered health care benefits or services program between the plan and an employer, an individual, or a government or other entity; or, in the case of a self-funded arrangement, the plan document that describes the Covered Services for a member.
Health Maintenance Organization (HMO) – A health benefit program that offers benefits to members when they obtain services from the network of physicians and hospitals designated as HMO Providers and Facilities. Benefits are eliminated when the member obtains care from a non-HMO provider, except for emergency services and authorized referrals. Generally, HMO members select a primary care provider.


Maximum Benefit Allowance (“MBA”) – “Maximum Benefit Allowance” means the maximum amount of reimbursement allowed for a Covered Service as determined by Anthem.

Medically Necessary or Medical Necessity – means the definition set forth in the member's Health Benefit Plan, unless a different definition is required by statute or regulation.

Medical Policy – Medical Policies serve as one of the sets of guidelines for coverage decisions. These policies address the Medical Necessity of existing, generally accepted services, technologies and drugs.

Participating and PPO Occupational Medicine Network – The network of health care providers, including facilities and ancillary providers, that have contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

Participating and PPO Occupational Medicine Network Provider – A facility, medical group practice, participating physician or other ancillary provider that has contracted with Anthem and/or one or more of its affiliates and other payers to provide compensable medical care for prospectively determined rates to injured workers.

Pay, Paid or Payment – to contractually settle a debt or obligation. After the maximum benefit allowance is determined, Anthem or the employer’s benefit plan will satisfy its portion of the bill by payment to the provider. The member’s portion of the payment includes a deductible, copayment and/or coinsurance, or other cost-sharing amounts, and, if the provider is non-participating, any amounts over the maximum benefit allowance. The amount Anthem pays a provider may not be the same as the allowable amount shown on the member’s EOB or on the provider’s bill.

Pre-certification – Authorization given before either an inpatient admission or outpatient procedure or service (a.k.a., prior authorization and/or pre-authorization)

Preferred Provider Organization (PPO) – A health benefit program under which members receive a higher level of benefits by receiving services from providers in an identified network.
**Pre-service Decision** – A review of medical care or services that Anthem conducts, in whole or in part, before a member obtains the medical care or services (e.g., prospective review). Pre-certification and pre-authorization are pre-service decisions.

**Post-service Decision** – Any review by Anthem of medical care or services already provided to a member (e.g., retrospective review).

**Primary Care Physician ("PCP")** – A physician who has entered into a written Agreement with Anthem to provide Covered Services to members and to coordinate and arrange for the provision of other health care services to members who have selected the physician as their PCP. A PCP is defined as one of the following specialties, Pediatrician, Family Practice, General Practice and/or Internal Medicine.

**Prior Benefit Authorization ("PBA")** – A determination made before a member receives certain services that meet all eligible-for-coverage criteria and that the services comply with the provisions of the member's Health Benefit Plan.

**Provider** – A health care professional, institutional health care provider, ancillary provider, hospital or any other entity that has entered into a written Agreement with Anthem to provide Covered Services to members, including upon appropriate referral, if necessary, by the member's PCP and/or Anthem. A non-participating provider is a provider who hasn’t entered into such an Agreement.

**Provider Policy and Procedure Manual** – Prepared by Anthem and which Anthem may amend solely at its discretion. This Manual sets forth the basic policies and procedures to be followed by providers in carrying out the terms and conditions of their Agreement with Anthem. The terms of the Provider Policy and Procedure Manual are part of such an Agreement.

**Prudent Lay Person Law** – State of Nevada Regulation 4-2-17, titled “Prompt Investigation of Health Plan Claims Involving Utilization Review”

**Referral** – Authorization given to a member by the member’s PCP for an office visit with another provider. Referrals don’t cover procedures performed outside the provider’s office or invasive procedures performed in the provider’s office.

**Reimbursement Policy (Professional)** – Professional Reimbursement Policies are a set of policies developed to document coding and pricing methodologies as well as clinical editing for certain specific services.

**Retrospective Review** – Conducted to evaluate the appropriateness of services and level of care after services have been rendered. Review may occur before or after the initial payment determination.
**Subscriber Liability** – The amount the subscriber (member) must pay the provider, such as deductibles, coinsurance and copayments, to satisfy contractual cost-sharing obligations.

**Utilization Review** – A set of formal techniques designed to monitor the use, or evaluate the clinical necessity, appropriateness, efficacy or efficiency, of health care services, procedures or settings. Techniques include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning and/or retrospective review. Utilization review also includes reviews to determine coverage. This is based on whether or not a procedure or treatment is considered experimental/investigational in a given circumstance (except if it’s a specific exclusion under the member’s Health Benefit Plan) and review of a member’s medical circumstances when necessary to determine if an exclusion applies in a given situation.

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**Exhibits**

Download Commonly Requested Forms

Download our commonly requested forms online. Go to anthem.com, select the Provider link in upper left corner. Select Nevada from drop down list and enter. Under the Answers@Anthem tab, select Download Commonly Requested Forms.

Downloads forms such as the following:

- Medical-Surgical Clinical Data Submission
- Provider Change Form
- Claim Action Request Form
- Provider Dispute Resolution Form
- Provider Refund Adjustment Request
- W-9 Form
- Designation of an Authorized Representative (DOR Form)
- Individual Authorization Form
- Psychotherapy Notes Authorization Form
- Coordination of Benefits (COB) Questionnaire
- Fax Authorization Form

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**Appendices**
Links

BlueCard® Website

Contact Us

Federal Employee Program (“FEP”) Website

List of Affiliates

Medical Policy, Clinical UM Guidelines, and Pre-Cert Requirements

Medicare Advantage