



MISSOURI PROVIDER MANUAL

September 2018

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Introduction and Guide to Manual

Purpose and Introduction

The purpose of this manual is to provide supplemental information to the applicable Anthem BlueCross and BlueShield facility or provider agreement (the "Agreement") and/or the compensation or payment schedule. This provider manual will present a general overview of information regarding key administrative areas; including but not limited to the quality improvement program, the utilization management program, quality standards for participation and administration policies and provider appeals.

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

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

Information Sources

- Anthem website – An internet site available to Anthem BlueCross and BlueShield ("Anthem") Providers and Facilities at www.Anthem.com. Select **Menu**, and then under the **Support** heading, select the **Providers** link. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. The site provides information on:
 - Anthem products
 - Contact phone numbers
 - Provider services
 - Health information
 - Provider directories
 - Network eUPDATES
- Network Update – A periodic newsletter publication designed to educate physicians, facilities, hospitals, and their appropriate staff on administrative issues.

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

Legal and Administrative Requirements Overview

Appointment Access and Geographic Availability

Anthem uses these standards and regulations(*) to assess the access of services and experience satisfaction of our Missouri Commercial and Healthcare Exchange Members. Offices are to make best effort to provide access in accordance with the Member's needs and suitable for their medical and behavioral health circumstances.

OFFICE APPOINTMENT ACCESSIBILITY	
Assessment of appointment timeliness to meet members needs	
MEDICAL APPOINTMENT ACCESS	COMPLIANCE
Emergency	Immediate access 24/7/365 or refer to ER or 911.
Urgent / Acute Care	Within 24 hours - <ul style="list-style-type: none">▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.▪ Patient is directed to Urgent Care, 911 or ER, as appropriate.
Routine Care with symptoms*	Within 5 business days - <ul style="list-style-type: none">▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.

Routine Care / Check-up without symptoms*	Within 30 calendar days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Preventive Care*	Within 60 calendar days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their doctor, another participating practitioner in the practice or a covering practitioner within the timeframe.
Office Wait Time	Recommended not to exceed 30 minutes before taken to the exam room.
After Hours Urgent Care	24/7/365 phone access - All Members shall have access to medical help or instructions after normal business hours through their primary care physicians 24/7 via: <ul style="list-style-type: none"> ▪ Live person connects the caller to their available doctor or on-call doctor. ▪ Recording or live person directs the patient to Urgent Care, 911, or ER as appropriate. ▪ <i>In addition to, but not in place of the above</i>, the caller may be directed to contact a live health practitioner (via cell, pager, beeper, transfer system) or get a call back for urgent instructions. A recording only instructing to go to ER is non-compliant. Having no provision is non-compliant.
BEHAVIORAL HEALTH (BH) APPOINTMENT ACCESS	COMPLIANCE
Emergency	Immediate access 24/7 or refer to ER, 911 or crisis center.
Discharge Follow-up BH Appointment	Within 7 days – <ul style="list-style-type: none"> ▪ <i>New or existing</i> patient can be seen in the office by designated BH practitioner within the timeframe after discharge from an inpatient psychiatric hospitalization.
Emergent - Non-Life Threatening	Within 6 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice, or a covering Practitioner within the timeframe; ▪ Patient is directed to 24-hour crisis services, 911, or ER as appropriate.
Urgent Care*	Within 24 hours - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice, or a covering practitioner within the timeframe; ▪ Patient is directed to 24-hour crisis services, 911 or ER, as appropriate.
Routine / Non-Urgent Care with symptoms*	Within 5 business days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice, or a covering Practitioner within the timeframe.
Routine – Initial Appointment	Within 10 days – <ul style="list-style-type: none"> ▪ <i>New</i> patient can be seen in the office by a designated BH practitioner, another participating practitioner within the timeframe. (After the intake assessment or referral.)
Routine – Follow-up Appointment	Within 30 calendar days - <ul style="list-style-type: none"> ▪ Patient can be seen in the office by their BH practitioner, another participating practitioner in the practice, or a covering practitioner within the timeframe.
After Hours Urgent Care (Required arrangements)	24/7/365 phone access – All Members shall have phone access to emergent/urgent instructions/consultation after regular business hours through their BH practitioner via: <ul style="list-style-type: none"> ▪ Recording or live person directs patient to ER, 911 or 24-hour crisis services, as appropriate.

	<ul style="list-style-type: none"> ▪ Caller is directed to contact a BH Practitioner (via transfer system, cell, pager, beeper) or get a call back for instructions or consultation. <p>Having no provision is non-compliant.</p>
Out of Office Coverage	<p>Arrangement for coverage when the practitioner is unavailable (vacation, illness, holiday, etc.) via:</p> <ul style="list-style-type: none"> ▪ Cell phone, pager, etc. ▪ Patient is directed to another practitioner in the practice, on call or covering practitioner. ▪ Prior arrangement with patients.
PROVIDER AVAILABILITY	
Assessment of numbers and types to meet members needs	
MEDICAL NETWORK ADEQUACY	
OPEN PRACTICE	At least 90% of Primary Care Physician's practices will be open for new patient selection.
<i>Note: Keep Anthem updated of status for web directory.</i>	
GEOGRAPHIC AVAILABILITY OF MEDICAL PROVIDERS	
Mileage is based upon member and provider zip code coordinates and locality definitions per GeoAccess® software.	
MEDICAL GEOGRAPHICS	MEASURE
<ul style="list-style-type: none"> • Primary Care Physicians: Family Medicine, Internal Medicine and Pediatrics. 	<ul style="list-style-type: none"> ▪ 2 of each type within 5 miles (urban) ▪ 2 of each type within 12 miles (suburban) ▪ 2 of each type within 30 miles (rural)
<ul style="list-style-type: none"> • OB/Gyn 	<ul style="list-style-type: none"> ▪ 1 within 15 miles (urban) ▪ 1 within 30 miles (suburban) ▪ 1 within 40 miles (rural)
<ul style="list-style-type: none"> • Specialists 	<ul style="list-style-type: none"> ▪ 1 of each major specialty type within 30 miles
<ul style="list-style-type: none"> • Hospitals 	<ul style="list-style-type: none"> ▪ 1 within 30 miles
<ul style="list-style-type: none"> • Skilled Nursing Facility 	<ul style="list-style-type: none"> ▪ 1 within 30 miles
BEHAVIORAL HEALTH NETWORK ADEQUACY	
GEOGRAPHIC AVAILABILITY OF BEHAVIORAL HEALTH PROVIDERS	
Mileage is based upon member and provider coordinates and locality definitions per GeoAccess® software.	
BH GEOGRAPHICS	MEASURE
<ul style="list-style-type: none"> • Psychiatrist (MD/DO) (Include Sub-Abuse) 	<ul style="list-style-type: none"> ▪ 2 within 10 miles (urban) ▪ 2 within 25 miles (suburban) ▪ 2 within 60 miles (rural)
<ul style="list-style-type: none"> • Non-MD Professionals: Psychologist and Masters Level Therapists (Include Sub-Abuse) 	<ul style="list-style-type: none"> ▪ 2 of each type within 10 miles (urban) ▪ 2 of each type within 25 miles (suburban) ▪ 2 of each type within 60 miles (rural)
<ul style="list-style-type: none"> • BH Treatment Facilities (Facilities offering IP BH services) 	<ul style="list-style-type: none"> ▪ 1 within 35 miles (urban /suburban combined) ▪ 1 within 75 miles (rural)
MULTICULTURAL HEALTH	
Practitioners meeting the needs and preferences of their patients	
<ul style="list-style-type: none"> • Doctors are expected to identify their patient's needs by explaining things in a way they can understand, listen carefully, show respect for what they have to say and spend enough time with the patient. • Anthem has provided offices with a tool (link below) that provides ideas, resources and tools that can help doctors and their staffs better understand and communicate with select patient groups with specific needs. This allows for patients to fully understand their medical situation and get the maximum benefit from their time with their doctor. • Please see the Multicultural Health section of this manual for more information on resources for Providers to help support addressing racial and ethnic disparities in health and healthcare. Features include CME learning experiences, real-life stories about unique challenges faced by diverse patients and tips and techniques to promote improved health outcomes. <p style="text-align: center;">https://mydiversepatients.com</p>	
<ul style="list-style-type: none"> • Practitioners can provide Anthem with their gender and race / ethnicity for the provider directory via the Provider Maintenance Form (PMF) at anthem.com. Select Menu, and then under the Support heading, select the Providers link. On the Provider landing page, choose Find Resources for Your State and pick your state from the list. Choose Answers@Anthem, Provider Maintenance Form. 	

This information will be utilized in online provider directories available to Members to locate a doctor who meets their cultural, racial, ethnic, gender and language needs and preferences.

Coordination of Benefits

If a Member or eligible dependent is covered by more than one Health Benefit Plan, the carriers involved work together to prevent duplicate payments for any services. This cooperative effort is called Coordination of Benefits ("COB"), a provision in most Health Benefit Plans.

If a Plan is other than the primary payor, any further compensation to Provider or Facility from Plan or the Member be determined in accordance with the Agreement, the applicable Health Benefit Plan and any applicable Plan written policies and procedures for coordinating benefits. Such compensation from Plan as a secondary payer plus the amounts owed by all other sources, including the Member, shall add up to one hundred percent (100%) of the Plan rate.

Notwithstanding the foregoing, in no event shall Plan or the Member be required to pay more than they would have paid had the Plan been the primary payor. Providers and Facilities will not collect any amount from the Member if such amount, when added to the amounts collected from the primary and secondary payors, would cause total reimbursement to the Provider or Facility for the Covered Service to exceed the amount allowed for the Covered Service under the Agreement. Further, this provision shall not be construed to require Providers or Facilities to waive Cost Share in contravention of any Medicare rule or regulation, nor shall this provision be construed to supersede any other Medicare rule or regulation. If, under this Section, Providers and Facilities are permitted to seek payment from other sources by reason of the existence of other group coverage in addition to Plan's Health Benefit Plan. Providers and Facilities may seek payment from the other sources on a basis other than the Plan rate.

Make the Most of Your Electronic Submissions Coordination of Benefits (COB)

Anthem provides a Companion Guide, to assist Providers and Facilities with the submission of electronic Claims. The Companion Guide contains complete instructions for the electronic billing of Coordination of Benefit Claims. If you would like to learn more, refer to the Companion Guide (appropriate 837 section) online. Go to anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. Next, select the **Access EDI** box, and **pick Your State**.

When filing Coordination of Benefits Claims on paper submission

Include Explanation of Benefit. ("EOB") from primary insurance carrier with coordination of benefits ("COB") Claims submitted for secondary payment.

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 Provider Agreement (the "Agreement") or the Anthem Facility Agreement (the "Agreement"). All administrative remedies set forth above shall be exhausted prior to filing an arbitration demand. The following provisions set forth some of the procedures and processes that must be followed during the exercise of the Dispute Resolution and Arbitration Provisions in the Agreement.

A. Attorney's Fees and Costs

The shared fees and costs of the non-binding mediation and arbitration (e.g. fee of the mediator, fee of the independent arbitrator, etc.) will be shared equally between the parties. Each party shall be responsible for the payment of that party's specific fees and costs (e.g. the party's own attorney's fees, the fees of the party selected arbitrator, etc.) and any costs associated with conducting the non-binding mediation or arbitration that the party chooses to incur (e.g. expert witness fees, depositions, etc.). Notwithstanding this provision, the arbitrator may issue an order in accordance with Federal Rule of Civil Procedure Rule 11.

B. Location of the Arbitration

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

C. Selection and Replacement of Arbitrator(s)

For disputes equal to or greater than (exclusive of interests, costs or attorney's fees), the dollar thresholds set forth in the Dispute Resolution and Arbitration Article of the Agreement the panel shall be selected in the following manner. The arbitration panel shall consist of one (1) arbitrator selected by Provider/Facility, one (1) arbitrator selected by Anthem, and one (1) independent arbitrator to be selected and agreed upon by the first two (2) arbitrators. If the arbitrators selected by Provider/Facility and Anthem cannot agree in thirty (30) calendar days on who will serve as the independent arbitrator, then the arbitration administrator identified in the Dispute Resolution

and Arbitration Article of the Agreement shall appoint the independent arbitrator. In the event that any arbitrator withdraws from or is unable to continue with the arbitration for any reason, a replacement arbitrator shall be selected in the same manner in which the arbitrator who is being replaced was selected.

D. Discovery

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

E. Decision of Arbitrator(s)

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

The arbitrator(s) may consider and decide the merits of the dispute or any issue in the dispute on a motion for summary disposition. In ruling on a motion for summary disposition, the arbitrator(s) shall apply the standards applicable to motions for summary judgment under Federal Rule of Civil Procedure 56.

Judgment upon the award rendered by the arbitrator(s) may be confirmed and enforced in any court of competent jurisdiction. Without limiting the foregoing, the parties hereby consent to the jurisdiction of the courts in the State(s) in which Anthem is located and of the United States District Courts sitting in the State(s) in which Anthem is located for confirmation and injunctive, specific enforcement, or other relief in furtherance of the arbitration proceedings or to enforce judgment of the award in such arbitration proceeding.

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

F. Confidentiality

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

[Financial Institution/Merchant Fees](#)

Providers and Facilities are responsible for any fees or expenses charged to it by their own financial institution or payment service provider.

[Insurance Requirements](#)

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

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

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

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

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

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

- Auto Liability insurance, which complies with all applicable state laws and/or regulations, and shall provide coverage for Claims arising out of acts, errors or omissions in the rendering or failure to render services.

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

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

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

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

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

[Misrouted Protected Health Information \(PHI\)](#)

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

[Missouri Autism Mandate](#)

Missouri law (at Section 376.1224, R.S.Mo) mandates coverage for the diagnosis and treatment of Autism Spectrum Disorders (“ASD”).

The bill requires coverage for fully insured and certain self-insured group policies and mandates an offer of coverage for individual policies. It requires that health carriers and health benefit plans provide coverage for the diagnosis and treatment of ASD ordered by a licensed physician or licensed psychologist acting within the scope of his or her license in accordance with a treatment plan. The mandate also requires health insurance coverage for applied behavior analysis (“ABA”) therapy for individuals through age eighteen (18).

Additional information on the Missouri autism mandate can be found at the Missouri state website at: <https://house.mo.gov/content.aspx?info=bills101/bills/HB1311.htm>.

[Open Practice](#)

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

[Privacy Policy Statement](#)

Information regarding Anthem’s Corporate Privacy Policy Statement that sets forth guidelines regarding a Member’s right to access and amend information in Anthem’s possession is available by selecting the “Privacy Statement” at the bottom of the Provider Landing page of our public provider website. To access this information go to anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider Landing page, scroll to the bottom and click on the “Privacy Statement” link.

[Provider and Facility Responsibilities](#)

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

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

Examples of these changes include, but are not limited to:

- adding a new practitioner to your group
- change in ownership
- change in Tax Identification Number
- making changes to your demographic information or adding new locations
- selling or transferring control to any third party
- acquiring other medical practice or entity
- change in accreditation
- change in affiliation
- change in licensure or eligibility status, or
- change in operations, business or corporation

[Referring to Non-Participating Providers](#)

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

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

[Risk Adjustments](#)

Compliance with Federal Laws, Audits and Record Retention Requirements

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

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

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

Encounter Data for Risk Adjustment Purposes

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

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

Maintaining documentation of Members' visits and of Members' diagnoses and chronic conditions helps Anthem fulfill its requirements under the Affordable Care Act. Those requirements relate to the risk adjustment, reinsurance and risk corridor, or "3Rs" provision ACA. To ensure that Anthem is reporting current and accurate Member diagnoses, Providers and Facilities may be asked to complete an Encounter Facilitation Form (also known as a SOAP note) for Members insured under small group or individual health benefit plans suspected of having unreported or out of date condition information in their records. Anthem's goal is to have this information confirmed and/or updated no less than

annually. As a condition of the Facility or Provider's Agreement with Anthem, the Provider or Facility shall comply with Anthem's requests to submit complete and accurate medical records, Encounter Facilitation Forms or other similar encounter or risk adjustment data in a timely manner to Anthem, Plan or designee upon request.

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

RADV Audits

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

ICD-10 CM Codes

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

Medical Record Documentation Requirements

Medical records significantly impact risk adjustment because:

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

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

HHS record documentation requirements include:

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

Directory of Services

[Provider Contracting and Provider Relations](#)

In order to meet the service needs of our Providers and Facilities, we have assembled an experienced staff consisting of Provider Service Representatives, Provider Network Managers, and Network Relations Consultants available to assist you.

Contact a **Provider Service Representative** by calling the Provider Inquiry Department at (888) 571-9054 or the phone number provided on the back of the Member's identification card ("ID") for questions/comments concerning:

Claims status
Eligibility
Claim reviews

Complaints
Claims coding and or submission

The **Network Relations Consultants** generally serve as a liaison and are responsible for on-site orientation, ongoing training and policy/procedure consult. They will assist you with administrative policies and procedures, problem resolution and service needs.

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

To locate your Anthem Network Relations Consultant's phone number you can utilize the Territory Listing located on anthem.com by following the directions below or clicking on the link provided.

Go to anthem.com

- Select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. Select "Contact Us" at the top of the page
- Select "Important Phone Numbers" for local telephone numbers and addresses.
- Select "Missouri Network Relations Consultants – Anthem Geographic Area Listing" for information on your local Anthem Network Relations Consultant.

Online Provider Directories and Demographic Data Integrity

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

[Online Provider Directory](#)

Providers and Facilities who have questions on their participation status are encouraged to contact Provider Services at (866-791-2292).

Accessing the Online Provider Directory:

- Go to anthem.com
- Select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list.
- To search our online Provider Directory either enter your member information or enter as guest.

If you are directing a Member to another Provider or Facility, please verify that the Provider or Facility is participating in the Member's specific network.

- To help ensure you are directing a Member to stay within his/her specific Network, utilize the Online Provider Directory one of the following ways:
 - **Search as a Member:** Search by entering the Member's ID number (including the three-character prefix), or simply enter the three-character prefix by itself.
 - **Search as Guest:** Search by Selecting a Plan or Network. Note: You can usually find the Member's Network Name on the lower right corner of the front of the Member's ID card.

[Updating your Demographic Data with Anthem](#)

It is critical that your patients receive accurate and current data related to provider availability. Please notify Anthem of any changes to your Provider and Facility information. All requests must be received 30 days **prior** to the change/update. Any requests received within less than 30 days' notice may be assigned a future effective date. Contractual terms may supersede effective date requests.

Notes:

- **Tax ID changes must be accompanied by a W-9 to be valid.**
- **For notices of termination from our network, refer to the termination clause in your Agreement for specific notification requirements. Please allow the number of days' notice of termination from our network as required by your Agreement (e.g. 90 days, 120 days, etc.).**

Types of demographic data updates can include, but are not limited to:

- Accepting New Patients
- Address – Additions, Terminations, Updates (including physical and billing locations)
- Areas of Expertise (Behavioral Health Only)
- Email Address
- Handicapped Accessibility
- Hospital Affiliation and Admitting Privileges
- Languages Spoken

- License Number
- Name change (Provider/Organization or Practice)
- National Provider Identifier (NPI)
- Network Participation
- Office Hours/Days of Operation
- Patient Age/Gender Preference
- Phone/Fax Number
- Provider Leaving Group, Retiring, or Joining another Practice*
- Specialty
- Tax Identification Number (TIN)
- Termination of Provider Participation Agreement
- Web Address

Please send us this information in one of the following ways:

- Online form:
- E-Mail Address:
- Fax Number:
- Address:

* Note: To request participation for a new provider or practitioner, even if joining an existing practice, providers or practitioners must first begin the Application process. Go to anthem.com, select **Providers** under Partner Login. Next, select **Begin Application**, and **pick your state**.

Anthem Provider Websites

www.Anthem.com

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

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

- Self Service and Support
 - Anthem Customized Claim Edits
 - Anthem Medical Policies and Clinical UM Guidelines
 - Anthem Reimbursement Policies
 - Behavioral Health Provider Resources
 - Cancer Care Quality Program
 - Credentialing
 - Cultural and Linguistic Provider Resources
 - Dental Provider Resources
 - Electronic Data Interchange (EDI)
 - Electronic Self-Service Options
 - Enhanced Personal Health Care
 - Precertification (Tools)
 - Precertification Guidelines
 - Provider Maintenance Form
 - Quick Contact Sheet
- Communications & Updates
 - Health Exchange Information
 - Health Care Reform and Notifications
 - ICD-10
 - Network eUPDATE
 - Network Update (Provider Newsletter)
- Our Plans & Benefits
 - Medicare Advantage
 - Plans & Benefits
- Health and Wellness
 - Practice Guidelines
- Contact Us

Availity Portal

Anthem is offering an array of online tools through the Availity Portal, a secure multi-health plan portal.

Get the information you need instantly with the following tools:

- **Care Reminders** – Receive clinical alerts on members' care gaps and medication compliance indicators, when available.
- **Claim Submission** – Submit a single, electronic Claim.
- **Claim Status Inquiry** – See details and payment information including Claim line-level details/processing.
- **Interactive Care Reviewer** – Secure, online provider precertification, referral and inquiry tool for many Anthem members.
- **Member Certificate Booklet** – View a local plan Member's certificate of coverage, when available.
- **Member eligibility and benefits inquiry** – Get real-time patient eligibility, benefits, and accumulative data, including current and historical coverage information, plus detailed co-insurance, co-payment and deductible information for ALL members, including BlueCard® and FEP®.
- **Secure Messaging** – Send a question to clarify the status of a Claim or to get additional information on Claims.

Payer Spaces:

View Anthem specific tools by selecting **Payer Spaces**, then the **Anthem icon** to view the following tools:

- **Clear Claim Connection** – Research procedure code edits and receive edit rationale.
- **Education and Reference Center** – Locate important policies, forms and educational resources. * Fee Schedule – Retrieves professional office-based contracted price information for patient services performed.
- **Remittance Inquiry** – View an imaged copy of the paper Anthem remits up to 15 months in the past.
- **Patient360** – Real time, robust picture of your patient's health and treatment history.
- **Plus**, links to other Anthem pages, tool overview documents and more, such as:
 - **AIM Specialty Health® (AIM)** – link to precertification requests and inquiries through AIM
 - **OptiNet® Survey on AIM** – link to the survey via AIM Specialty Health.

Take advantage of these Availity benefits

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

How to get started

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

If you need further assistance registering, please contact Availity Client Services at 1-800-AVAILITY (282-4548).

Availity Training

Once you log into Availity, you will have access to many resources to help jumpstart your learning, including free and on-demand training, frequently asked questions, comprehensive help topics and other resources to help ensure you get the most out of your Availity experience. Availity also offers onboarding modules for new Administrators and Users.

If you would like more information on navigating in Availity, select **Help & Training** (from the top navigation menu on the Availity home page) | **Get Trained**, and type "onboarding" in the search catalog field. Or, go to **Help & Training | My Learning Plan**, and plot your learning journey.

Availity Training for Anthem specific tools

For more information on Anthem features and navigation, select **Payer Spaces| Applications | Education and Reference Center** to find presentations and reference guides that can be used to educate provider staff on Anthem proprietary tools.

Organization Maintenance

To change/update an Administrator or Organization information:

- To replace the Administrator currently on record with Availity, please call Availity Client Services at 1-800-AVAILITY (282-4548).
- An Administrator can use the Maintain Organization feature to maintain the organization's demographic information, including address, phone number, tax ID, and NPI. Any changes made to this information

automatically apply to all Users associated to the organization and affects only the registration information on the Availity Portal.

Member Identification Card

It is important that Providers, Facilities and their staff are able to locate all the necessary information on Member's ID cards. Below are some common and important items that you need to know:

Member ID Number – Member ID numbers are found on the ID card under the Member's name. The ID numbers contain three-digit prefixes, which are critical in the routing and processing of your Claim.

Network - Knowing the Member's Network will assist you in identifying the applicable Anthem Rate. You need to have this information when registering Members in your office. The Network (Blue Access®, Blue Access Choice®, Blue Preferred®, Pathway®, or Pathway X®) will be in the upper, right-hand corner of the ID card and/or at the bottom of the ID card. Be sure this is the Network in which you participate and that you refer the Member to other Network/Participating Providers and Facilities within their Network if needed. Members who receive services outside of their Network may have no benefits or reduced benefits, which could impact the Member's financial responsibilities as well as the potential payment for providers.

Be sure to look first for the local Network name on the ID card (Blue Access, Blue Access Choice, or Blue Preferred). If you do not see a local Network name on the ID card, then refer to the suit case logo on the ID card to identify the Network. A blank suitcase logo on a Member's ID card means that the Member may access our Traditional or Regular Network. If there is no local Network name on the ID card, but there is a "PPO in a suitcase" logo, the Blue Access Network applies. Additional information is located on the Anthem provider web site under BlueCard®.

Front of the card

The logo will be displayed in the upper left corner.

- Member Name (First Middle Last)
- Identification Number
- Prefix

Group/product information

Network name

Anthem		BlueAccess Choice
Member Name		Medical PCP not required
Identification Number XXX1234567800		
Group	XXXXXXXXXX	Deductible
Plan	XXXXXXXXXX	Office Visit
RxBIN	XXXXXXXXXX	Specialist
RxPCN	XXXXXXXXXX	Emergency Room
		Urgent Care
		RX Tier 1/RX Tier2
		RX Tier 3
		\$XX/\$XX
		XX%
		XX%
		XX%
		XX%
		\$XX/\$XX
		\$XX
BlueAccess Choice		

Product name

Prescription Drug information, if applicable

Medical copay information

The PPO/empty suitcase and prescription drug logo will be displayed at the bottom right, if applicable.

Back of the card

The logo will be displayed on the back of the card in the upper left corner.

Mailing addresses will be placed on the left side of the card.

Number used for internal use only

Anthem		anthem.com
Providers: Please file medical claims with the local Blue Cross and Blue Shield Plans in the state where services were provided. When Medicare is primary (including Med. supp. policies), file first with Medicare in the state where services were provided.		
Possession of this card does not guarantee eligibility for benefits.		
Mail claims to: Anthem, P.O. Box 36550, Louisville, KY 40233		
<small>In Missouri (including 90 counties in the Kansas City area), Anthem Blue Cross and Blue Shield is the local name for Regence® Manager Care, Inc. (RC), Healthy Member® Life Insurance Company (HLC), and WMO Missouri, Inc. RC and certain affiliates administer non-MHI benefits underwritten by HMO and HMO health maintenance organizations (HMOs). RC and certain affiliates only provide administrative services for self-funded plans and do not underwrite benefits. Independent members of the Blue Cross and Blue Shield Association. ® and HMO is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross and Blue Shield names and symbols are registered marks of the Blue Cross and Blue Shield Association.</small>		
XXXX (1/09)		

The web address is displayed above the phone numbers on the right side of the card.

The phone numbers will be placed on the right side of the card.

(Please note there can be variations in the ID cards.)

Claims Submission

Service Area

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

Missouri counties: Adair, Audrain, Barry, Barton, Bollinger, Boone, Butler, Callaway, Camden, Cape Girardeau, Carter, Cedar, Chariton, Christian, Clark, Cole, Cooper, Crawford, Dade, Dallas, Dent, Douglas, Dunklin, Franklin, Gasconade, Greene, Hickory, Howard, Howell, Iron, Jasper, Jefferson, Knox, Laclede, Lawrence, Lewis, Lincoln, Linn,

Macon, Madison, Maries, Marion, McDonald, Miller, Mississippi, Moniteau, Monroe, Montgomery, Morgan, New Madrid, Newton, Oregon, Osage, Ozark, Pemiscot, Perry, , Phelps, Pike, Polk, Pulaski, Putnam, Ralls, Randolph, Reynolds, Ripley, Schuyler, Scotland, Scott, Shannon, Shelby, St. Charles, St. Francois, St. Louis, St. Louis City, Ste. Genevieve, Stoddard, Stone, Sullivan, Taney, Texas, Warren, Washington, Wayne, Webster, Wright.

Illinois counties: Madison, Monroe, St. Clair

[Claim Submission Filing Tips](#)

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

Electronic Claims Submissions

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

Paper Claims Submissions

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

- Submit all paper Claims using the current standard RED CMS-1500 (02-12) for professional Claims and the UB-04 (CMS-1450) for Facility Claims.
- If Providers or Facilities are submitting a multiple page Claim, the word “continued” should be noted in the total charge field, with the total charge submitted on the last page of the Claim.
- When submitting a multiple page document, do not staple over pertinent information.
- Complete all mandatory fields.
- Do not highlight any fields.
- Check the printing of Claims from time to time to help ensure proper alignment and that characters are legible.
- Ensure all characters are inside the appropriate fields and do not overlap.
- Change the printer cartridge regularly and do not use a DOT matrix printer.
- Submit a valid member identification number including three-digit prefix or R+8 numeric for Federal Employee Program® (FEP®) members on all pages.
- Claims must be submitted with complete provider information, including referring, rendering and billing NPI; tax identification number; name; and servicing and billing addresses on all pages.

Ambulatory Surgical Centers

When billing revenue codes, always include the CPT or HCPCS code for the surgery being performed. This code is required to determine the procedure, and including it on the Claim assists in processing the Claim correctly and more quickly. Ambulatory surgical Claims must be billed on a CMS-1500 (Form 1500 (02-12) or CMS-1450 (UB04), as indicated in Providers of Facilities Agreement.

Ancillary Filing Guidelines

Ambulance Claims

- Include the Point of Pickup (POP) ZIP Code for all ambulance (including air ambulance) Claims, both institutional outpatient and professional.
- File the Claims to the plan whose service area the Point of Pickup (POP) ZIP Code is located.
- The POP (Point of Pick-up) ZIP Code should be submitted as follows:
 - Professional Claims – for CMS-1500 submitters: the POP ZIP code is reported in field 23
 - Institutional outpatient Claims – for UB submitters: the Value Code of ‘A0’ (zero), and the related ZIP Code of the geographic location from which the beneficiary was placed on board the ambulance, should be reported in the Value Code Amount field and billed with the appropriate revenue 54x codes.

Durable/Home Medical Equipment and Supplies

- Durable/Home Medical Equipment and Supplies (D/HME) is determined by the provider specialty code in the provider file, not by CPT codes.

- Delivered to patient's home – File the Claim to the plan in the service area where the item was sent/delivered.
- Purchased at retail store – File the Claim to the plan in the service area where the retail store is located.

Home Infusion Therapy - Services and Supplies

- File the Claim with the plan in the service area where the services are rendered or the supply was delivered. Examples: If services are rendered in a member's home, Claims should be sent to the plan in the member's state. If Supplies are delivered to the member's home, Claims should be sent to the plan in the member's state.

Laboratory Claims

- File the Claim to the plan in the service area where the specimen was drawn, as determined by the referring provider's location (based on NPI)
- Independent lab Claims are determined by the provider specialty code in the provider file, not by CPT codes.

Specialty Pharmacy Claims

- File the Claim to the plan in the service area where the referring provider is located (based on NPI).
- Specialty pharmacy Claims are determined by the provider specialty code in the provider file, not by CPT codes.

Duplicate Claims (aka Tracers)

Providers and Facilities should refrain from submitting a Claim multiple times to avoid potential duplicate denials. Providers or Facilities can check the status of Claims via Availity.

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 using the PWK attachment face sheet. (See Electronic Data Interchange website for instructions as www.anthem.com/edi).

Late charges for Claims previously filed can be submitted via paper. Type of bill should contain a 5 in the 3rd position of the TOB (ex: 135). A late billing should contain ONLY the additional late charges. The Provider should also advise the original claim# to which the late charges should be added.

National Drug Codes (NDC)

See separate subsection titled National Drug Codes.

Negative Charges

When filing Claims for procedures with negative charges, please do not 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.

Not Otherwise Classified ("NOC") Codes

When submitting Not Otherwise Classified (NOC) codes please follow these guidelines to avoid possible Claim processing delays:

- If the NOC is for a drug, include the drug's name, dosage NDC number and number of units.
- If the NOC is not a drug, include a specific description of the procedure, service or item.
- If the item is durable medical equipment, include the manufacture's description, model number and purchase price if rental equipment.
- If the service is a medical or surgical procedure, include a description on the Claim and submit medical record/and the operative report (if surgical) that support the use of an NOC and medical necessity for the procedure.
- If the NOC is for a laboratory test, include the specific name of the laboratory test(s) and/or a short descriptor of the test(s)

NOTE: NOC codes should only be used if there are no appropriate listed codes available for the item or service. Descriptions should be include in the shaded area for item 24 on professional Claim forms, or locator 43 on facility Claim forms.

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.

Other Insurance Coverage

When filing Claims with other insurance coverage, please ensure the following fields are completed and that a legible copy of the Explanation of Benefits (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)

Field 9d: Insurance plan name or program name (not required in EDI)

UB-04 CMS-1450 Fields:

Field 50a-c: Payer Name

Field 54a-c: Prior payments (if applicable)

Including Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB):

When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) attached, the EOMB should indicate Medicare's Assignment. When submitting a CMS Form 1500 (02-12) or CMS-1450 (UB04) Claim form with an Explanation of Medicare Benefits (EOMB) or other payer Explanation of Benefits (EOB) attached, the EOMB or EOB should match each service line and each service line charge submitted on the CMS Form 1500 (02-12) or CMS-1450 (UB04).

Preventive Colonoscopy – correct coding

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 or Facilities of services. Frequently the Provider or Facility will bill for the CPT code with an ICD-10 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 ICD-10 diagnosis code Z12.11 (Encounter for screening for malignant neoplasm of colon) should be entered as the primary diagnosis and that the ICD-10 diagnosis code for any discovered pathology should be entered as the secondary 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 or Facility receives the correct reimbursement for services rendered and that our members receive the correct benefit coverage for this important service.

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.

[Claim Inquiry/Adjustment Filing Tips](#)

If Providers or Facilities believe a Claim was not processed correctly according to the terms of their Agreement, for example, Providers or Facilities believe the allowable is not correct. Providers or Facilities can submit a Provider Adjustment Request Form or send a secure message through Availity. The Provider Adjustment Request Form can be found on our public provider website under Answers@Anthem, Provider Forms. Please follow the instructions for completion and mailing.

Here are some additional tips that will help to ensure appropriate routing of the Provider or Facility requests.

- Submit one Provider Adjustment Request Form for each Claim. Do not submit lists of multiple Claims or multiple members on one Provider Adjustment Request Form. Requests with multiple Claims attached will be returned.
- Explain the nature of the request; including details on what Providers or Facilities would like researched

- Always include a valid and complete member identification number including the three-character prefix or R+8 digits for Federal Employee Program® (FEP®) members on the first page.
- Clearly identify the date of service in question on the first page.
- Insure that all information is legible whether it is printed or hand-written.

Different Types of Inquiries

The different types of inquiries should be handled in separate ways depending on what is being requested. Here are some examples:

- **Reconsiderations:** When requesting a review without additional records being attached such as benefit, pricing, or Claim review, it is often faster to utilize the provider contact number listed on the back of the member's card or by sending a Secure Message on Availity with the Provider or Facility's inquiry.
- **Additional Information/Records Needed (solicited):** When additional records are being submitted in response to our request or to support an appeal, please submit them via mail or fax to the appropriate department as directed in the letter received from Anthem to ensure a fast, accurate response. Always include the Anthem letter requesting records to the top of the records. A copy of the Claim is not needed. Please do not place copy of Claim on top of the records.
 - If Providers or Facilities are submitting medical records on compact disk (CDs), do not password protect the CDs. Remember to include a valid and complete member identification number (including three-character prefix) on page one of the material sent with these records.
 - If Providers or Facilities are submitting X-Rays, pictures or dental molds, remember to include a valid and complete member identification number on page one of the material sent with these items.
 - If Providers or Facilities are not including attachments with Provider or Facility requests, Providers or Facilities may receive a faster response by sending a Secure Message via Availity.
- **Precertification Disputes:** Precertification disputes should be handled via the process detailed in the letter received from our precertification department. If Providers or Facilities disagree with a clinical decision, please follow the directions detailed on our letter. Sending precertification/predetermination requests or appeals to the provider correspondence address may delay responses.
- **Corrected Claims:** Submitting corrected Claims should only be utilized to update information on the Claim form. If the inquiry is about the way the Claim processed, please refer to the prior sections. If Providers or Facilities have corrections to be made to the Claim, please submit according to the Corrected Claim Guidance below.
 - Corrected Claim forms must be submitted with all charges listed including Provider or Facility changes as a complete Claim. Adjustments will be made based on Providers or Facilities corrected Claim form. For example, if Providers or Facilities correct one line on a Claim bill the entire Claim with the corrections made on the applicable line that needs correcting. If the Claim is billing with only the single line that is corrected, we will assume Providers or Facilities removed the other lines as billed in error.
 - For Paper Submissions, the type of bill should contain a 7 in the 3rd position of the TOB (ex: 137). The Provider should submit the original charges in addition to the new charges on the same bill. The Provider should also advise the original claim# to which the corrections should be made.
- **Inquiries:** Inquiries as to why a Claim did not process as expected can be sent via Secure Messaging on Availity or our provider services department.

Corrected Claim Guidance

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

Type	Professional Claim	Institutional Claim
EDI	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7 	To indicate the Claim is a replacement Claim: <ul style="list-style-type: none"> • In element CLM05-3 "Claim Frequency Type Code" • Use Claim Frequency Type 7
	To confirm the Claim which is being replaced:	To confirm the Claim which is being replaced:

	<ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF! and list the original payer Claim number is REF02 	<ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF! and list the original payer Claim number is REF02
	<p>To indicate the Claim was billed in error (Void/Cancel):</p> <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8 	<p>To indicate the Claim was billed in error (Void/Cancel):</p> <ul style="list-style-type: none"> In element CLM05-3 "Claim Frequency Type Code" Use Claim Frequency Type 8
	<p>To confirm the Claim which is being void/cancelled:</p> <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF! and list the original payer Claim number is REF02 	<p>To confirm the Claim which is being void/cancelled:</p> <ul style="list-style-type: none"> In Segment "REF – Payer Claim Control Number" Use F8 in REF! and list the original payer Claim number is REF02
Paper	<p>To indicate the Claim is a replacement Claim:</p> <ul style="list-style-type: none"> In Item Number 22: "Resubmission and/or Original Reference Number" Use Claim Frequency Type 7 under "Resubmission Code" 	<p>To indicate the Claim is a replacement Claim:</p> <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 7
	<p>To confirm the Claim which is being replaced:</p> <ul style="list-style-type: none"> In the right-hand side of Item Number 22 under "Original Ref. "No.", list the original payer Claim number for the resubmitted Claim. 	<p>To confirm the Claim which is being replaced:</p> <ul style="list-style-type: none"> In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the resubmitted Claim.
	<p>To indicate the Claim is a void/cancel of a prior Claim:</p> <ul style="list-style-type: none"> In Item Number 22: "Resubmission and/or Original Reference Number" Use Claim Frequency Type 8 under "Resubmission Code" 	<p>To indicate the Claim is a void/cancel of a prior Claim:</p> <ul style="list-style-type: none"> In Form Locator 04: "Type of Bill" Use Claim Frequency Type 8
	<p>To confirm the Claim which is being void/cancelled:</p> <ul style="list-style-type: none"> In the right-hand side of Item Number 22 under "Original Ref. "No.", list the original payer Claim number for the void/cancelled Claim. 	<p>To confirm the Claim which is being void/cancelled:</p> <ul style="list-style-type: none"> In Form Locator 64: "Document Control Number (DCN)" list the original payer Claim number for the void/cancelled Claim.

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

[National Drug Codes \(NDC\)](#)

All practitioners and providers are required to 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. Note: These billing requirements will apply to Local Plan and BlueCard member Claims only, and will exclude Federal Employee Program (FEP) and Coordination of Benefits/ Secondary Claims.

Line items will deny if Healthcare Common Procedure Coding System (HCPCS) codes or Current Procedural Terminology (CPT) codes, for drugs administered in a physician office or outpatient facility setting AND do not include the following:

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
- ME - Milligram

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.



National Drug Codes (NDC) Number Section	Description
1 (five digits)	Vendor/distributor identification
2 (four digits)	Generic entity, strength and dosage information
3 (two digits)	Package code indicating the package size

Correcting Omission of a Leading Zero

Providers and Facilities may encounter NDCs with fewer than 11-digits. In order to submit a Claim, Providers and Facilities will need to convert the NDC to an 11-digit number. 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 to the beginning of the segment(s) that is missing the zero.
- Do not enter any of the hyphens on Claim forms.

See the examples that follow:

If the NDC appears as...	Then the NDC...	And it is reported as...
NDC 12345-1234-12 (5-4-2 format)	Is complete	12345123412
NDC 1234-1234-1 (4-4-1 format)	Needs a leading zero placed at the beginning of the first segment and the last segment	01234123401
NDC 12345-123-12 (5-3-2 format)	Needs a leading zero placed at the beginning of the second segment	12345012312
NDC 12345-1234-1 (5-4-1 format)	Needs a leading zero placed at the beginning of the third segment	12345123401

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:
 - KO – Single drug unit dose formulation
 - KP – First drug of a multiple drug unit dose formulation
 - KQ – Second or subsequent drug of a multiple drug unit dose formulation
 - JW – Drug amount discarded /not administered to the patient

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.

All Elements are REQUIRED:

How	Example	Where
Enter a valid NDC code including the N4 qualifier	NDC 000543252763 is entered as N400054352763	Beginning at the left edge, enter NDC in the shaded area of box 24A
Enter one of the five (5) units of measure qualifiers; <ul style="list-style-type: none"> • F2 – International Unit • GR – Gram • ML – Milliliter • UN – Units • ME – Milligrams and quantity, including a decimal point for correct reporting	GR03045 ML1.0 UN1.000	In the shaded area immediately following the 11-digit NDC, enter 3 spaces, followed by one of the five (5) unities of measure qualifiers, followed immediately by the quantity
Enter a valid HCPCS or CPT code	J0610 “Injection Calcium Gluconate, per 10 ml” is billed as 1 unit for each 10 ml ampule used	Non-shaded area of box 24D

Sample Image of the CMS 1500 Claim Form

The image shows a portion of the CMS-1500 Claim Form. A callout bubble points to the shaded area of box 24A, with the text: "Enter NDC in shaded area of box 24A". The form includes columns for dates of service, procedure codes, diagnosis pointers, charges, units, and rendering provider ID.

UB04 Claim Form:

- 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.

All Elements are REQUIRED:

How	Example	Where
Enter a valid revenue code	Pharmacy Revenue Code 0252	Form locator (box) 42
Enter 11-digit NDC, including the 4 qualifier	NDC 00054352763 is entered as N400054352763	Beginning at left edge, enter NDC in locator (box) 43 currently labeled as “Description”
Enter one of the five (5) units of measure qualifiers; <ul style="list-style-type: none"> • F2 – International Unit 	GR0.045 ML1.0 UN1.000	Immediately following the 11 digit NDC, enter 3 spaces followed by one of five (5) units of measure

<ul style="list-style-type: none"> GR – Gram ML – Milliliter UN – Units ME – Milligrams and quantity, including a decimal point for correct reporting		qualifiers, followed immediately by the quantity
Enter a valid HCPC or CPT Code	J0610 “injection Calcium, per 10ML” is billed as 1 unit for each 10LM ampule used	Form locator (box 44)

Sample Images of the UB04 Claim Form

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HPRO CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGE	48 NONCOVERED CHARGE	49
						0:00	
						0:00	
						0:00	

42 REV. CD	43 DESCRIPTION	44 HCPCS / RATE / HPRO CODE	45 SERV. DATE	46 SERV. UNITS	47 TOTAL CHARGE	48 NONCOVERED CHARGE	49
####	N4##### GR0.045	J####	MMDDYY	1	##.##	0:00	

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:

Tips for Using NDCs When Submitting Electronic Claims

Loop	Segment	Element Name	Information	Sample
2410	LIN02	Product or Service ID Qualifier	Enter product or NDC qualifier N4	LIN**N4*01234567891~
2410	LIN03	Product or Service ID	Enter the NDC	LIN**N4*01234567891~
2410	CTP04	Quantity	Enter quantity billed	CTP****2*UN~
2410	CTP05-1	Unit of Basis for Measurement Code	Enter the NDC unit of measurement code: F2: International Unit GR: Gram ML: Milliliter UN: Unit ME: Milligram	CTP****2*UN~
2410	REF01	Reference ID Qualifier (used to report Prescription # or Link Sequence Number when reporting components for a Compound Drug)	VY: Link Sequence Number XZ: Prescription Number	REF01*XZ*123456~
2410	REF02	Reference Identification	Prescription Number or Link Sequence Number	REF01*XZ*123456~

[Recommended Fields for Electronic 837 Professional \(837P\) and Institutional \(837I\) Health Care Claims](#)

Please reference our Transaction Specific Companion Documents available on our EDI webpage. Go to www.anthem.com/edi. Select your state from the dropdown list and enter. Under the Documents tab, select Companion Guide, then see the appropriate link under the Section B – Transaction Specific Companion Documents heading.

Recommended Fields for Paper CMS Form 1500 (02-12) Claims

If these are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

- Field 1a: Insured’s ID Number – from Member ID card, including any three-character prefix
- Field 2: Patient’s Name – do not use nicknames or middle names
- Field 3: Patient’s Birth Date – date of birth should be 8-digit (MM|DD|YYYY) format and Sex
- Field 4: Insured’s Name – “same” is acceptable if the insured is the patient

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

Field 6: Patient Relationship to Insured

Field 7: Insured's Address

Field 10: Is Patient's Condition Related to:

Field 10A: Employment?

Field 10B: Auto Accident?

Field 10C: Other Accident?

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

Important information about Fields 14 and 15:

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

Field 14: Date of Current Illness, Injury or Pregnancy (LMP) (if applicable) – Enter the 8-digit (MM|DD|YYYY) date of the present illness, injury, or pregnancy. For pregnancy, use the date of the last menstrual period (LMP) as the first date. Enter the applicable qualifier to identify which date is being reported:

- 431 – Onset of current symptoms or illness
- 484 – Last Menstrual Period

Field 15: Other Date – Enter another date related to the patient's condition or treatment. Enter the date in the 8-digit (MM|DD|YYYY) format. Enter the applicable qualifier to identify which date is being reported:

- 454 – Initial treatment
- 304 – Latest visit or consultation
- 453 – Acute manifestation or a chronic condition
- 439 – Accident
- 455 – Last X-ray
- 471 – Prescription
- 090 – Report start (assumed care date)
- 091 – Report end (relinquished care date)
- 444 – First visit or consultation

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

Field 17: Referring physician name – Enter the name of the referring or ordering provider. Enter the applicable qualifier to the left of the vertical, dotted line:

- DN – Referring provider
- DK – Ordering provider
- DQ – Supervising provider

Field 17b: Referring physician NPI

Field 21: Diagnosis or Nature of Illness or Injury – enter the appropriate diagnosis code/nomenclature – Relate A-L to Field 24E

Field 21: ICD Ind - ICD Indicator must be submitted between the vertical, dotted lines in the upper right-hand portion of the field or Claim may be rejected. Enter "9" for Code Set ICD-9-CM diagnosis for dates of service prior to 10/01/2015 or "0" for Code Set ICD-10 diagnosis for dates of service 10/01/2015 and later.

Field 22: Resubmission and/or Original Reference Number – This field is not intended for original Claim submissions. When resubmitting a Claim, enter the original Anthem Claim number and the appropriate bill

frequency code (7=Replacement of prior Claim; 8=Void/Cancel of prior Claim) left justified in the left-hand side of the field.

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

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

Field 24A: Date(s) of Service

Field 24B: Place of Service

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

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

Field 24F: \$ Charges – line item charge.

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

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

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

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

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

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

Field 32a: Service Facility's National Provider Identification number (NPI) – Service location NPI

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

Reminder: If submitting Claims electronic, this field must hold a physical address and should not contain any of the following: "Post Office Box", "P.O. Box", "PO Box", "Lock Box", "Lock Bin", "PO Box"

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

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



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA										PICA																			
1. MEDICARE <input type="checkbox"/> (Medicare#) <input type="checkbox"/> MEDICAID <input type="checkbox"/> (Medicaid#) <input type="checkbox"/> TRICARE <input type="checkbox"/> (ID#/DoD#) <input type="checkbox"/> CHAMPVA <input type="checkbox"/> (Member ID#) <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> (ID#) <input type="checkbox"/> FECA BLK LUNG <input type="checkbox"/> (ID#) <input type="checkbox"/> OTHER <input type="checkbox"/> (ID#) <input type="checkbox"/>					1a. INSURED'S I.D. NUMBER (For Program in Item 1)																								
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)					3. PATIENT'S BIRTH DATE MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>					4. INSURED'S NAME (Last Name, First Name, Middle Initial)																			
5. PATIENT'S ADDRESS (No., Street)					6. PATIENT RELATIONSHIP TO INSURED Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other <input type="checkbox"/>					7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					CITY					STATE														
ZIP CODE					TELEPHONE (Include Area Code)					ZIP CODE					TELEPHONE (Include Area Code)														
()					()					()					()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)					10. IS PATIENT'S CONDITION RELATED TO: a. EMPLOYMENT? (Current or Previous) <input type="checkbox"/> YES <input type="checkbox"/> NO b. AUTO ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO PLACE (State) _____ c. OTHER ACCIDENT? <input type="checkbox"/> YES <input type="checkbox"/> NO 10d. CLAIM CODES (Designated by NUCC)					11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER										b. INSURED'S DATE OF BIRTH MM DD YY SEX M <input type="checkbox"/> F <input type="checkbox"/>																			
b. RESERVED FOR NUCC USE										b. OTHER CLAIM ID (Designated by NUCC)																			
c. RESERVED FOR NUCC USE										c. INSURANCE PLAN NAME OR PROGRAM NAME																			
d. INSURANCE PLAN NAME OR PROGRAM NAME										d. IS THERE ANOTHER HEALTH BENEFIT PLAN? <input type="checkbox"/> YES <input type="checkbox"/> NO <i>If yes, complete items 9, 9a, and 9d.</i>																			
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED _____ DATE _____										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED _____																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL. _____					15. OTHER DATE MM DD YY QUAL. _____					16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE 17a. _____ 17b. NPI _____										18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? \$ CHARGES <input type="checkbox"/> YES <input type="checkbox"/> NO																			
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. _____										22. RESUBMISSION CODE ORIGINAL REF. NO.																			
A. _____ B. _____ C. _____ D. _____ E. _____ F. _____ G. _____ H. _____ I. _____ J. _____ K. _____ L. _____										23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER			E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSDT (mark Plan)		I. ID. QUAL.		J. RENDERING PROVIDER ID. #										
1																													
2																													
3																													
4																													
5																													
6																													
25. FEDERAL TAX I.D. NUMBER SSN EIN <input type="checkbox"/> <input type="checkbox"/>					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (If or gov't deems, see back) <input type="checkbox"/> YES <input type="checkbox"/> NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. Rsvd for NUCC Use				
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED _____ DATE _____										32. SERVICE FACILITY LOCATION INFORMATION a. NPI _____ b. _____										33. BILLING PROVIDER INFO & PH # () a. NPI _____ b. _____									

NUCC Instruction Manual available at: www.nucc.org

PLEASE PRINT OR TYPE

APPROVED OMB-0938-1197 FORM 1500 (02-12)

Recommended Fields for Paper UB-04 (CMS-1450) Claims

If these fields are not completed, Claims may be delayed or returned to the Provider or Facility for additional information.

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

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

- If there is a Combined Deductible + Coinsurance + Copay amount on the EOMB greater than zero, there must be a corresponding Value code of A1, B1, C1, 08, 09, 11, A2, B2, C2 A7, B7 or C7 and amount on the UB04.
- If there is a Value Code present and not equal to 02 there must be a Value Code amount.

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

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

Common errors in Fields 39-41:

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

- Value codes are missing. Value codes A1, B1, C1 are deductibles. Value codes 09, 11, A2, B2 and C2 are coinsurance. Value codes A7, B7 and C7 are copay. Value code 06 is blood deductible.
- The member deductible is missing or does not match the EOMB (Explanation of Medicare Benefits). If there is a deductible amount indicated on the primary payer's remittance advice, the UB04 must include the member deductible (A1, B1 or C1 value code) and amount.
- The coinsurance amount is missing. If there is coinsurance on the primary payer's remittance advice, the UB04 must include the coinsurance amount (09, 11, A2, B2 or C2 value code).
- The copay amount is missing. If there is copayment on the primary payer's remittance advice, the UB04 must include the copay amount (A7, B7, or C7 value code).
- Blood deductible is not noted. If there is blood deductible on the payer's remittance advice, the value code 06 must be on the Claim, along with the amount.
- There are errors in listing multiple value codes. If more than one value code is submitted on lines a – d, please fill in fields 39a, 40a or 41a before populating 39b, 40b, or 41b.

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

- Field 42: Revenue Code(s) – When submitting Revenue Code 011X or 11X and/or 014X or 14X, (X = numeric value) a value code of 01 with an amount greater than zero OR a value code of 02 with zero charges or blank must also be submitted.
- Field 43: Description – NDC: When submitting an unlisted drug HCPCS code, please submit the National Drug Code (NDC) in the shaded area above the drug code. Submit qualifier N4 followed immediately by the 11 digit NDC code. The NDC quantity should be submitted in positions 17-24 of the same line. The Quantity should be preceded by the appropriate Qualifier. UN (units), F2 (international units), GR (gram), ME (milligram) or ML (milliliter). The total dosage administered in mgs or mls can be reported in the shaded section and should not be reported in the Units field. The Service Units Field (46) represents the number of units based on the NDC number.
- Field 44: HCPCS/Accommodation Rates/HIPPS Rate Codes
- Field 45: Service Date
- Field 46: Service Units
- Field 47: Total Charges
- Field 56: Providers National Provider Identification number (NPI)
- Field 58: Insured's Name
- Field 59: Patient's Relationship
- Field 60: Insured Unique ID – from Member ID card, including any prefix/suffix
- Field 66: Diagnosis and Procedure Code Qualifier (ICD Version Indicator) – The qualifier that denotes the version of International Classification of Diseases (ICD) reported. The following qualifier codes reflect the edition portion of the ICD: 9 -Ninth Revision for dates of service prior to 10/01/2015 or 0 -Tenth Revision for dates of service 10/01/2015 and later.
- Field 67: Principal Diagnosis Code and Present on Admission (POA) Indicator
- Fields 67A-Q: Other Diagnosis Code(s) and Present on Admission (POA) Indicator(s)
- Field 74: Principal Procedure Code and Date

1	2	3a PAT. CNTL. #	4 TYPE OF BILL
5 MED. REC. #	6 STATEMENT COVERS PERIOD FROM	7 THROUGH	8
9 PATIENT NAME	a	9 PATIENT ADDRESS	a
10 BIRTHDATE	11 SEX	12 DATE	13 HR
14 TYPE	15 SRC	16 DHR	17 STAT
18	19	20	21
22	23	24	25
26	27	28	29
30	31	32	33
34	35	36	37
38	39	40	41
42	43	44	45
46	47	48	49
50	51	52	53
54	55	56	57
58	59	60	61
62	63	64	65
66	67	68	69
70	71	72	73
74	75	76	77
78	79	80	81
82	83	84	85
86	87	88	89
90	91	92	93
94	95	96	97
98	99	100	101

Electronic Data Interchange (EDI) Overview

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

There are several methods of transacting Anthem Claims through the EDI process. You can use electronic Claims processing software to submit Claims directly, a billing company, or a clearinghouse that acts as the third party between the Provider or Facility and Anthem. Submitting via EDI may require additional hardware and software needed to automate other tasks in your office such as receiving the 835 Electronic Remittance Advice (ERA). No matter what method you choose, Anthem does not charge a fee to submit electronically. Providers and Facilities engaging in electronic transactions should familiarize themselves with the HIPAA transaction requirements.

Electronic Funds Transfer (“EFT”)

Providers or Facilities seeking to register or manage account changes for EFT only, or EFT and ERA combined, will need to use the Council for Affordable Quality Health Care (CAQH) Enrollment Tool called EnrollHub (at

<https://solutions.caqh.org/>), a secure electronic ERA/EFT registration platform. This tool will help eliminate the need for paper registration and reduce administrative time and costs and allow you to register with multiple payers at one time.

Providers or Facilities previously registered with Anthem to receive combined ERA/EFT or EFT (only) will register with CAQH's EnrollHub to manage account changes, but otherwise do not need to take action.

Additional Information

For additional information concerning electronic Claims submission and other electronic transactions, you can click the Electronic Data Interchange (EDI) link below or go to www.anthem.com/edi select "Missouri". [Access Electronic Data Interchange \(EDI\) Services](#)

Overpayments

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

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

Anthem's Cost Containment Overpayment Avoidance Division also requests refunds for overpayments identified by other Divisions of Anthem, such as Provider Audit or the Special Investigations Unit.

Anthem Identified Overpayment (aka "Solicited")

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

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

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

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

Provider and Facility Identified Overpayments (aka "voluntary" or "unsolicited")

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

- Submit a refund check with supporting documentation outlined below, or
- Submit the Provider Adjustment Form available on anthem.com with supporting documentation to have Claim adjustment/recoupment done off a future remittance advice. To download the "Provider Adjustment Form" directly from anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the provider home page, select Answers@Anthem on the menu bar. On the Answers@Anthem page, select "Provider Forms" and "Provider Adjustment Request Form". Providers can also reference the Links sections of the manual for the direct link information.

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

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

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

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

How to access the Provider Adjustment Form online:

IN, KY, MO, OH, and WI Providers: To download the “Provider Adjustment Form” directly from anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the provider home page, select Answers@Anthem on the menu bar. On the Answers@Anthem page, select “Provider Forms” and “Provider Adjustment Request Form”. Providers can also reference the Links section of the manual for the direct link information.

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

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

[MO Prompt Pay -Requests for Additional Information](#)

Requests for additional information for processing a Claim must be forwarded to a provider-using facsimile or email in compliance with Missouri law at Section 376.383, R.S.Mo. The fax number and/or email address should be for the person within your practice/Facility that handles requests for additional information needed for processing a Claim. To update our database you will need to complete the Provider Maintenance Form that is housed on the provider website under the Answers@Anthem tab. Please allow forty-five (45) days for the database to be updated.

This requirement is for fully insured and Non-ERISA self-funded benefit plans and applies to Claims that are submitted electronically. For additional information, please access the website at:

<http://www.house.mo.gov/billtracking/bills101/biltxt/truly/HB1498T.HTM>

[Medicare Crossover](#)

[Duplicate Claims Handling for Medicare Crossover](#)

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

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

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

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

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

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

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

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

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

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

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

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

Effective October 13, 2013:

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

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

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

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

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

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

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

Medicare Crossover Claims FAQs

1. How do I handle traditional Medicare-related Claims?

- When Medicare is primary payer, submit Claims to your local Medicare intermediary.
- All Blue Claims are set up to automatically cross over (or forward) to the Member's Blue Plan after being adjudicated by the Medicare intermediary.

2. How do I submit Medicare primary / Blue Plan secondary Claims?

- For Members with Medicare primary coverage and Blue Plan secondary coverage, submit Claims to your Medicare intermediary and/or Medicare carrier.
- When submitting the Claim, it is essential that you enter the correct Blue Plan name as the secondary carrier. This may be different from the local Blue Plan. Check the Member's ID card for additional verification.
- Be certain to include the three-character prefix as part of the Member identification number. The Member's ID will include the three-character prefix in the first three positions. The three-character prefix is critical for confirming membership and coverage, and key to facilitating prompt payments.

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

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

3. Who do I contact with Claims questions?

- Your local Anthem Plan.

4. How do I handle calls from Members and others with Claims questions?

- If Members contact you, tell them to contact their Blue Plan. Refer them to the front or back of their ID card for a customer service number.
- A Member's Blue Plan should not contact you directly, unless you filed a paper Claim directly with that Blue Plan. If the Member's Blue Plan contacts you to send another copy of the Member's Claim, refer the Blue Plan to your local Anthem Plan.

5. Where can I find more information?

For more information:

- Visit Anthem's Web site at www.anthem.com.

Please contact your local Anthem Plan.

Reimbursement Policies and Procedures

[Blood, Blood Products, Processing, Storage and Administration](#)

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

[Changes During Admission](#)

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

CHANGE	EFFECTIVE DATE
Member's Insurance Coverage	Admission
Facility's Payment Methodology	Admission
Facility's Payment Rate	Admission
DRG Grouper Version	Discharge
DRG Relative Weight	Discharge

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

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

The DRG Grouper Version, as well as the DRG Relative Weight used are the ones in effect upon discharge.

[Coding Requirements](#)

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

[Comprehensive Health Planning](#)

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

[Coordination of Benefits/Subrogation](#)

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

To the extent permitted by law, Plan may, under third party liability, third party recovery, or similar provisions of Health Benefit Plans, service agreements, certificates or other documents setting forth terms and conditions of health coverage, become entitled to refunds of benefit amounts paid by Plan.

However, the right of Plan to such a refund will not, in any case, affect or increase the maximum compensation to which Provider or Facility is entitled under the Agreement for any services that are, or in the absence of Plan's right to such refund would be, Covered Services.

Courtesy Room

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

Daily Supply or One Time Charge Fees/Items

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

Different Settings Charges

If Anthem determines that Facility submits Charges differently for the same service performed in a different setting, Plan will reimburse the lesser of the two (2) applicable Anthem Rates.

Eligibility and Payment

A guarantee of eligibility is not a guarantee of payment.

Emergency Room Supply and Service Charges

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

Facility Personnel Charges

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

Fifty percent (50%) Copayment Rule

Pursuant to Missouri law, Members covered by Missouri HMO products and Members who receive chiropractic care should not be charged a copayment that is more than fifty percent (50%) of the total cost of that service. Please make best efforts to collect no more than 50% of the allowed amount at the time of service for chiropractic services rendered to fully-insured members and for all services rendered to fully-insured HMO members. When a Network/Participating Provider submits a Claim, Anthem will determine if the Member's copayment on his/her identification card is more than fifty percent (50%) of the allowed amount for the service(s) provided. If the Member's copayment is more than fifty percent (50%) of the allowed amount, Anthem will adjust the Member's copayment so that it does not exceed the fifty percent (50%) limit. Anthem will then pay up to the remaining allowed amount. The remittance advice will indicate if the adjustment is made as a result of the copayment law. If Anthem adjusts the copayment the Network/Participating Provider must reimburse owe the Member any difference between the copayment amount and the adjusted copayment amount.

An example of the correct process:

A fully-insured member receives care at the office of Dr. Smith, a Network/ Participating chiropractor. The contracted allowed amount for the service is \$50 and the member's copayment is \$40. Dr. Smith collects \$25 from the member (50% of the allowed amount), and submits the Claim to Anthem. Upon adjudication, Anthem adjusts the member's copayment from \$40 to \$25 pursuant to Missouri law, and pays Dr. Smith \$25 (the remaining allowed amount). Dr. Smith has collected the full allowed amount (\$25 from the member and \$25 from Anthem).

[General Industry Standard Language](#)

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

[Implants](#)

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

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

["Incident to" Billing](#)

Anthem does not follow CMS "Incident to" payment rules for any physician or non-physician provider (NPP) who has been assigned or is waiting for his/her own National Provider Identification (NPI). Physicians or non-physician providers (NPP) who are eligible to receive their own NPI and whose specialty is recognized by Anthem must submit their Claims directly to Anthem under their own NPI. Physician or non-physician provider (NPP) are not permitted to bill under a supervising provider's NPI even in the event they have applied for an NPI or their application for an NPI is pending.

Certain services rendered in the office setting are separately reportable under Current Procedural Terminology (CPT®) coding guidelines. These separately reportable services are considered "Incident to" when performed by qualified auxiliary office personnel who, are not eligible to directly submit Claims to Anthem and, therefore, not eligible to receive direct payment. Examples of such qualified auxiliary office personnel include, but are not limited to, registered or licensed practical nurses, medical assistants, and technicians.

[Instrument Trays](#)

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

[Interim Bill Claims](#)

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

[IV Sedation- IV sedation and local anesthesia](#)

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

[Labor Care Charges](#)

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

[Medical Care Provided to or by Family Members](#)

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

Unless otherwise set forth in a Member's Health Benefit Plan, an immediate family member includes: father, mother, children, spouse, domestic partner, legal guardian, grandparent, grandchild, sibling, step-father, step-mother, step-children, step-grandparent, step-grandchild, and/or step-sibling.

Mother/Baby Claims

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

Non-Participating Provider Claims Payment Policy

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

Nursing Procedures

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

Observation Services Policy

Description

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

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

Policy

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

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

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

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

[Operating Room Time and Procedure Charges](#)

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

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

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

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

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

[Other Agreements Excepted](#)

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

[Personal Care Items](#)

Personal care items used for patient convenience are not payable. 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 paid or billable to the patient. Examples include but are not limited to: bedpans, chux, hot water bottles, icepacks, pillows, sitz baths, and urinals.

[Pharmacy Charges](#)

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

Place of Service and Evaluation & Management Facility Reimbursement Policy

Description

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

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

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

Policy

- Services that are rendered in an office, professional building, medical office building, clinic or a space owned by a hospital or an institutional provider, other than the primary structure on the campus of the hospital or institutional provider, or rented by a professional from the hospital or an institutional provider, must be billed on a CMS-1500 Claim form and are not reimbursable if they are billed on a UB-04 Claim form.
- Anthem shall not separately reimburse a clinic fee or any other facility fee associated with space used to provide E&M services in the event they are billed on a UB-04 Claim form.
- Anthem does not reimburse for professional E&M charges billed on a UB-04 Claim form regardless of where services are rendered; reimbursement for these charges are included in the professional fee allowance.
- All professional services including, but not limited to, those rendered by hospital-based physicians such as emergency room physicians, radiologists, anesthesiologists, hospitalists, independent practitioners, physical therapists, occupational therapists, speech therapists, and Certified Registered Nurse Anesthetists (CRNA) must be billed on a CMS-1500 Claim form using the appropriate CPT[®]/HCPCS codes.
- Services rendered outside of the primary structure on the campus of a hospital or an institutional provider shall not be billed or reimbursed on a UB-04 Claim form. The Member is not responsible for these charges. Examples of Revenue Codes under which such services shall not be billed or reimbursed include, but are not limited to, the following groupings:

- 0280 – 0289 Oncology Clinic
- 0300 – 0309 Laboratory
- 0300 – 0319 Laboratory Pathological
- 0320 – 0329 Radiology Diagnostic
- 0330 – 0339 Radiology – Therapeutic and/or Chemotherapy Administration
- 0340 – 0349 Nuclear Medicine
- 0350 – 0359 CT Scan
- 0420 – 0429 Physical Therapy
- 0430 – 0439 Occupational Therapy
- 0440 – 0449 Speech Therapy
- 0481 – 0489 Cardiology Clinic
- 0510 – 0519 Clinic
- 0520 – 0529 Free Standing Clinic
- 0530 – 0539 Osteopathic Services
- 0540 – 0549 Ambulance
- 0610 – 0619 Magnetic Resonance Technology
- 0630 – 0637 Pharmacy
- 0740 – 0749 Sleep Study
- 0760 – 0769 Treatment or Observation Room
- 0770 – 0779 Preventive Care Codes
- 0780 – 0789 Telemedicine
- 0960 – 0989 Professional Fees

Professional E&M services shall not be billed or reimbursed on a UB-04 Claim form. The Member is not responsible for these charges.

Portable Charges

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

Pre-Operative Care or Holding Room Charges

Charges for a preoperative (pre-op) care or holding room used prior to a procedure are included in the payment for the procedure and are not billed separately. In addition, nursing care provided in the pre-operative care area will not be reimbursed separately. Payment for the procedure includes all nursing care provided.

Preparation (Set-Up) Charges

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

Preventable Adverse Events (“PAE”) Policy

Acute Care General Hospitals - PAE Policy

Three (3) Major Surgical Never Events

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

Whenever any of the events described in the grid below occur with respect to a Member, 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.

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

CMS Hospital Acquired Conditions (“HAC”)

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

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

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

Four (4) Major Surgical Never Events

When any of the Preventable Adverse Events (“PAEs”) set forth in the grid below occur with respect to a Member, the Provider or Facility shall neither bill, nor seek to collect from, nor accept any payment from the Health Plan **or** the Member for such events. If Provider or Facility receives any payment from the Health Plan or the Member for such events, it shall refund such payment within ten (10) business days of becoming aware of such receipt.

Further, Providers and Facilities shall cooperate with Anthem, in any Anthem initiative designed to help analyze or reduce such PAEs.

Whenever any of the events described in the grid below occur with respect to a Member, 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.

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

Provider and Facility Records

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

Psychiatric Outpatient/Residential Services

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

Anthem recognizes the below Levels of Care. These levels differ in terms of the degree of services required, as defined by the combination of ICD-10 or successor diagnosis codes and revenue codes.

Level 1

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

Level 2

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

Special billing instructions and requirements:

1. ICD-10 or successor diagnosis codes must be included for each care level. The appropriate ICD-10 or successor codes are 290.0 to 319.
2. Appropriate revenue codes must be included for each care level. Utilization management must approve the level of care for all services.
3. Each service date must be billed as a separate line item.
4. Whole hours must be used to indicate hours of care in the “Service Units” field. Show whole hours in form locator 46.

[Recovery Room Charges](#)

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

[Routine Maternity Ultrasounds](#)

Two routine maternity ultrasounds are considered for payment if the member has a benefit for the services.

- Payment for routine maternity ultrasounds in excess of two (2) will be reviewed and may be recovered through a post audit process.
- The limitation of (two) does not apply to Medically Necessary maternity ultrasounds as well as Claims from the following providers; Emergency Room, Fetal Medicine and Radiologist.

[Special Procedure Room Charge](#)

Special procedure room Charges are included in the payment for the procedure.

[Stand-by Charges](#)

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

[Stat Charges](#)

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

[Submission of Claim/Encounter Data](#)

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

[Telemetry](#)

Telemetry charges in Emergency Room ("ER") and intensive care unit ("ICU") or telemetry unit are included in the payment for the place of service. Additional monitoring charges are not paid.

[Test or Procedures Prior to Admission\(s\) or Outpatient Services](#)

The following diagnostic services, defined by specific Coded Service Identifier(s), are considered part of pre-admission/pre-surgical/pre-operative testing:

- 254 – Drugs incident to other diagnostic services
- 255 – Drugs incident to radiology
- 30X – Laboratory
- 31X – Laboratory pathological
- 32X – Radiology diagnostic
- 341 – Nuclear medicine, diagnostic
- 35X – CT scan
- 40X – Other imaging services
- 46X – Pulmonary function
- 48X –Cardiology
- 53X – Osteopathic services
- 61X – MRI
- 62X – Medical/surgical supplies, incident to radiology, or other services
- 73X – EKG/ECG

74X – EEG

92X – Other diagnostic services

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

Time Calculation

- Operating Room ("O.R.") – O.R. time should be calculated from the time the patient enters the room until the patient leaves the room, as documented on the O.R. nurse's notes.
- Anesthesia – Time charges should be calculated from the start and finish times as documented on the anesthesia record.
- Anesthesia materials may be charged individually as used or included in a charge based on time. A charge that is based on time will be computed from the induction of the anesthesia until surgery is complete. This charge will include the use of all monitoring equipment. Other types of anesthesia such as local, regional, 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. Charges are not to exceed the approved average semi-private room rate.

Undocumented or Unsupported Charges

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

Video Equipment used in Operating Room

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

Additional Reimbursement Policies and Procedures

Anthem's public provider website is your source for reimbursement policies. Go to anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose, **Find Resources for Your State** and pick your state from the list. Select **Answers@Anthem** from the horizontal menu and choose **Reimbursement Policies-Facility** or **Reimbursement Policies-Professional**. You can also access the policies via the Availity Portal. If you are a registered Availity user, log into Availity, select the "Payer Spaces" with Anthem as the Payer. Choose "Education and Reference Center" and under "Administrative Support", choose "Reimbursement Policies-Facility" or "Reimbursement Policies-Professional".

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

Medical Policies and Clinical Utilization Management (UM) Guidelines

The Office of Medical Policy & Technology Assessment ("OMPTA") develops medical policy and clinical UM guidelines (collectively, "Medical Policy") for Anthem. The principal component of the process is the review for development of Medical Necessity and/or investigational policy position statements or clinical indications for certain new medical services and/or procedures or for new uses of existing services and/or procedures. The services consisting of medical, surgical, and behavioral health treatments include, but are not limited to devices, biologics and specialty pharmaceuticals, and professional health services.

The Medical Policy & Technology Assessment Committee ("MPTAC") is a multiple disciplinary group including physicians from various medical specialties, clinical practice environments and geographic areas. Voting membership may include external physicians in clinical practices and participating in networks, external physicians in academic practices and participating in networks, internal medical directors and Chairs of MPTAC Subcommittees. Non-voting members may include internal legal counsel and internal medical directors.

Additional details regarding the Medical Policy development process, including information about MPTAC and its Subcommittees, is provided in ADMIN.00001 Medical Policy Formation.

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

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

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

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

To locate Medical Policy online, go to anthem.com, select **Providers** under Partner Login. Choose **Read Policies**, and pick your state, then select one of the following links:

- [Medical Policy and Clinical UM Guidelines \(for Local Plan members\)](#)
- [Medical Policy and Clinical UM Guidelines \(for BlueCard/Out-of-area members\)](#)

Clinical UM Guidelines for Local Plan members

The clinical UM guidelines published on our website represent the clinical UM guidelines currently available to all Plans for adoption throughout our organization. Because local practice patterns, claims systems and benefit designs vary, a local Plan or line of business may choose whether to implement a particular clinical UM guideline. The link below can be used to confirm whether the local Plan or line of business has adopted the clinical UM guideline(s) in question. Adoption lists are created and maintained solely by each local Plan or line of business.

To view the list of specific clinical UM guidelines adopted by Missouri, navigate to the Disclaimer page by following the instructions above for Medical Policy and Clinical UM Guidelines (for Local Plan members); scroll to the bottom of the page. Above the “Continue” button, select the link titled “Specific Clinical UM Guidelines adopted by Anthem Blue Cross and Blue Shield of Missouri.”

Utilization Management

[Utilization Management Program](#)

Providers and Facilities agree to abide by the following Utilization Management (“UM”) Program requirements in accordance with the terms of the Agreement and the Member’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:

[UM Definitions](#)

1. **Pre-service Review:** Review for Medical Necessity that is conducted on a health care service or supply prior to its delivery to the Member.
2. **Initial Request/Continued Stay Review (continuation of services):** Review for Medical Necessity during initial/ongoing inpatient stay in a facility or a course of treatment, including review for transitions of care and discharge planning.
3. **Pre-certification/Pre-authorization Request:** For Anthem UM team to perform Pre-service Review, the provider submits the pertinent information as soon as possible to Anthem UM prior to service delivery.
4. **Pre-certification/Pre-authorization Requirements:** List of procedures that require Pre-service Review by Anthem UM prior to service delivery.
5. **Business Day:** Monday through Friday, excluding designated company holidays.

6. **Notification:** The telephonic and/or written/electronic communication to the applicable health care Providers, Facility and the Member documenting the decision, and informing the health care Providers, Facility and Member of their rights if they disagree with the decision.
7. **Adverse Decision:** An Anthem utilization review decision that a health care service rendered or proposed to be rendered was or is not Medically Necessary or is investigational.

Pre-service Review & Continued Stay Review

- A. Provider or Facility shall ensure both requirements (1) and (2) are met: (1) that non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are submitted for review and have a decision rendered before the service occurs. Information provided to Anthem shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section. (2) For non-emergency admissions. Provider or Facility shall also provide confirmation to Anthem UM of the necessary demographic information and primary diagnosis within twenty-four (24) hours or next Business Day of following the Member's admission.
- B. If an Emergency admission has occurred, Provider or Facility shall notify Anthem UM within forty-eight (48) hours or the first Business Day following admission. If the forty-eight (48) hours expires on a day that is not a Business Day the timeframe will be extended to include the next Business Day. Information provided to Anthem shall include demographic and clinical information including, but not limited to, primary diagnosis. For information on applicable penalties for non-compliance see Failure to Comply with Utilization Management Program section.
- C. Provider or Facility shall verify that the Member's primary care physician has provided a referral as required by certain Health Benefit Plans.
- D. Provider or Facility shall comply with all requests for medical information for Continued Stay Review required to complete Anthem's review up to and including discharge planning coordination. To facilitate the review process, Provider or Facility shall make best efforts to supply requested information within twenty-four (24) hours of request.
- E. Anthem specific Pre-certification/Pre-authorization Requirements may be confirmed on the Anthem web site or by contacting customer service.

Medical Policies and Clinical UM Guidelines

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

On-Site Review

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

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

Discharge Planning

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

Observation Bed Policy

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

Retrospective Utilization Management

Retrospective UM is designed to review post service Claims for Health Services in accordance with the Member's Health Benefit Plan and Anthem medical policy and clinical guidelines. Medical records and pertinent

information regarding the Member's care may be reviewed by health care professionals with review by peer clinical reviewers when necessary to determine the level of coverage for the Claim, if any. This review may consider such factors as the Medical Necessity of services provided, whether the Claim involves cosmetic or experimental/investigative procedures, or coverage for new technology treatment.

[Failure to Comply With Utilization Management Program](#)

Provider and Facility acknowledge that Anthem may apply monetary penalties such as a reduction in payment, as a result of Provider's or Facility's failure to provide notice of admission or obtain Pre-service Review on specified outpatient procedures, as required under this Agreement or for Provider's or Facility's failure to fully comply with and participate in any cost management programs and/or UM programs. Members may not be balance billed for penalty amounts. Penalties include but are not limited to the following:

If non-emergency admissions and outpatient procedures that require Pre-certification/Pre-authorization as specified by Anthem are not submitted for review and a decision rendered before the service occurs payment will be subject to a 30% penalty.

Payment for emergency inpatient admissions will be subject to a 30% penalty if the notification is not provided within forty-eight (48) hours of admission. If the forty-eight (48) hours expires on a day that is not a Business Day the time frame will be extended to include the next Business Day.

[Case Management](#)

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

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

[Utilization Statistics Information](#)

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

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

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

[Electronic Data Exchange](#)

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

[Reversals](#)

Utilization Management favorable determinations will not be reversed unless;

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

[Peer to Peer Review Process](#)

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

Initiating a Peer-to-Peer Review Request: Providers can initiate a peer-to-peer request **IF** he/she is the attending, treating or ordering physician, Nurse Practitioner, or Physician Assistant who provides the care for

which any adverse medical necessity determination is made. In compliance with nationally recognized guidelines from the National Committee for Quality Assurance (NCQA) and URAC, Provider or his/her designee may request the peer-to-peer review. Others such as hospital representatives, employers and vendors are not permitted to do so.

[Quality of Care Incident](#)

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

[Audits/Records Requests](#)

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

[Interactive Care Reviewer \(ICR\)](#)

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

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

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

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

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

AIM Specialty Health® (AIM)

AIM Specialty Health provides clinical solutions that drive appropriate, safe, and affordable care. Serving more than 50 million members across 50 states, D.C. and U.S. territories, AIM promotes optimal care through use of evidence-based clinical guidelines and real-time decision support for both providers and their patients. The AIM platform delivers significant cost-of-care savings across an expanding set of clinical domains, including radiology, cardiology, oncology, specialty drugs, sleep medicine, musculoskeletal care, and genetic testing.

Visit AIM's program websites to find program information, clinical guidelines, interactive tutorials, worksheets & checklists, FAQs, and access to AIM **ProviderPortals**SM

- Radiology: www.aimprovider.com/radiology
- Cardiology: www.aimprovider.com/cardiology
- Medical Oncology : www.cancercarequalityprogram.com
- Radiation Oncology: www.aimprovider.com/radoncology
- Genetic Testing: www.aimprovider.com/genetictesting
- Sleep: www.aimspecialtyhealth.com/gowebssleep
- Specialty Drugs: www.aimprovider.com/specialtyrx
- Musculoskeletal: www.aimprovider.com/msk

Submit Pre-certification requests to AIM

Ordering and servicing Providers may submit pre-certification requests to AIM in one of the following ways:

- Access AIM **ProviderPortal** directly at providerportal.com. Online access is available 24/7 to process orders in real-time, and is the fastest and most convenient way to request authorization.
- Access AIM via the Availity Portal at availity.com
- Call the AIM Contact Center toll-free number: 800-554-0580.

OptiNet® Registration

The **OptiNet** Registration is an important tool that assists ordering providers in real-time decision support information to enable ordering providers to choose a high quality, low cost imaging providers for their patients. Servicing providers need to complete the **OptiNet** Registration online.

To access the **OptiNet** Registration:

- Access AIM **ProviderPortal** directly at providerportal.com. You may also access AIM via the Availity Portal at availity.com
- Once logged into AIM, from the My Homepage screen, choose Access Your **OptiNet** Registration.
- Select the Registration Type, and choose the Access Your **OptiNet** Registration button.
- Complete requested information.

The registration does not need to be completed in one sitting. Data can be saved as you proceed through the registration. Once the registration has been submitted, a score card will be produced. The score for the Facility will be presented to the ordering Provider when the particular Facility is selected as a place of service which drives Ordering Provider Decision Support.

For technical questions, contact AIM **ProviderPortal**/Web Support at 800-252-2021. For any other questions, contact your Anthem Provider Relations Representative.

Credentialing

[Anthem's Discretion](#)

The credentialing summary, criteria, standards, and requirements set forth herein are not intended to limit Anthem's discretion in any way to amend, change or suspend any aspect of its credentialing program nor is it intended to create rights on the part of practitioners who seek to provide healthcare services to our Members. Anthem further retains the right to approve, suspend, or terminate individual physicians and health care professional, and sites in those instances where it has delegated credentialing decision making.

[Credentialing Scope](#)

Anthem credentials the following licensed/state certified independent health care practitioners:

- Medical Doctors (MD)
- Doctors of Osteopathic Medicine (DO)
- Doctors of Podiatry

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

The following behavioral health practitioners are not subject to professional conduct and competence review under Anthem's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing board to independently provide behavioral health services and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Certified Behavioral Analysts
- Certified Addiction Counselors
- Substance Abuse Practitioners

Anthem credentials the following Health Delivery Organizations ("HDOs"):

- Hospitals
- Home Health Agencies
- Skilled Nursing Facilities (Nursing Homes)
- Ambulatory Surgical Centers
- Behavioral Health Facilities providing mental health and/or substance abuse treatment in inpatient, residential or ambulatory setting, including:
 - Adult Family Care/Foster Care Homes
 - Ambulatory Detox
 - Community Mental Health Centers ("CMHC")
 - Crisis Stabilization Units
 - Intensive Family Intervention Services
 - Intensive Outpatient – Mental Health and/or Substance Abuse
 - Methadone Maintenance Clinics
 - Outpatient Mental Health Clinics
 - Outpatient Substance Abuse Clinics
 - Partial Hospitalization – Mental Health and/or Substance Abuse
 - Residential Treatment Centers ("RTC") – Psychiatric and/or Substance Abuse
- Birthing Centers
- Home Infusion Therapy when not associated with another currently credentialed HDO

The following Health Delivery Organizations are not subject to professional conduct and competence review under Anthem's credentialing program, but are subject to a certification requirement process including verification of licensure by the applicable state licensing agency and/or compliance with regulatory or state/federal contract requirements for the provision of services:

- Clinical laboratories (CLIA Certification of Accreditation or CLIA Certificate of Compliance)
- End Stage Renal Disease (ESRD) service providers (dialysis facilities)(CMS Certification)
- Portable x-ray Suppliers (FDA Certification)
- Home Infusion Therapy when associated with another currently credentialed HDO (CMS Certification)
- Hospice (CMS Certification)
- Federally Qualified Health Centers (FQHC) (CMS Certification)
- Rural Health Clinics (CMS Certification)

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's Credentials Committee ("CC").

The CC will meet at least once every forty-five (45) calendar days. The presence of a majority of voting CC members constitutes a quorum. The chief medical officer, or a designee appointed in consultation with the vice president of Medical and Credentialing Policy, will designate a chair of the CC, as well as a vice-chair in states or regions where both Commercial and Medicaid contracts exist. The chair must be a state or regional lead medical director, or an Anthem medical director designee and the vice-chair must be a lead medical officer or an Anthem medical director designee, for that line of business not represented by the chair. In states or regions where only one line of business is represented, the chair of the CC will designate a vice-chair for that line of business also represented by the chair. The CC will include at least five, but no more

than ten external physicians representing multiple medical specialties (in general, the following specialties or practice-types should be represented: pediatrics, obstetrics/gynecology, adult medicine (family medicine or internal medicine); surgery; behavioral health, with the option of using other specialties when needed as determined by the chair/vice-chair). CC membership may also include one to two other types of credentialed health providers (e.g. nurse practitioner, chiropractor, social worker, podiatrist) to meet priorities of the geographic region as per chair/vice-chair's discretion. At least two of the physician committee members must be credentialed for each line of business (e.g. Commercial, Medicare, and Medicaid) offered within the geographic purview of the CC. The chair/vice-chair will serve as a voting member(s) and provide support to the credentialing/re-credentialing process as needed.

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

During the credentialing process, all information that is obtained is confidential and not subject to review by third parties except to the extent permitted by law. Access to information will be restricted to those individuals who are deemed necessary to attain the objectives of Anthem's credentialing program. In particular, information supplied by the Practitioner or HDO in the application, as well as other non-publicly available information will be treated as confidential. Confidential written records regarding deficiencies found, the actions taken, and the recommended follow-up will be kept in a secure fashion. Security mechanisms include secured office facilities and locked filing cabinets, a protected computer infrastructure with password controls and systematic monitoring, and staff ethics and compliance training programs. The procedures and minutes of the CC will be open to review by state and federal regulating agencies and accrediting bodies to the extent permitted by law.

Practitioners and HDOs 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 or HDO within thirty (30) calendar days of the identification of the issue. This communication will notify the practitioner or HDO of the right to correct erroneous information or provide additional details regarding the issue in question. This notification will also include the 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 documented in the practitioner's credentials file. The practitioner or HDO will be given no less than fourteen (14) calendar days in which to provide additional information. On request, the practitioner will be provided with the status of their credentialing or recredentialing application.

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 programs or provider network(s) on the basis of race, gender, color, creed, religion, national origin, ancestry, sexual orientation, age, veteran, or marital status or any unlawful basis not specifically mentioned herein. Additionally, Anthem will not discriminate against any applicant on the basis of the risk of population they serve or against those who specialize in the treatment of

costly conditions. Other than gender and language capabilities which are provided to the members to meet their needs and preferences, this information is not required in the credentialing and re-credentialing process. Determinations as to which practitioners and providers require additional individual review by the Credentials Committee are made according to predetermined criteria related to professional conduct and competence. Credentials Committee decisions are based on issues of professional conduct and competence as reported and verified through the credentialing process. Anthem will audit credentialing files annually to identify discriminatory practices, if any, in the selection of practitioners. Should discriminatory practices be identified through audit or through other means, Anthem will take appropriate action(s) to track and eliminate those practices.

Initial Credentialing

Each practitioner or HDO must complete a standard application form deemed acceptable by Anthem when applying for initial participation in one or more of Anthem’s Networks or Plan Programs. For practitioners, the Council for Affordable Quality Healthcare (“CAQH”) ProView system is utilized. To learn more about CAQH, visit their web site at www.CAQH.org.

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

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

A. Practitioners

Verification Element
License to practice in the state(s) in which the practitioner will be treating Members.
Hospital admitting privileges at a TJC, NIAHO or AOA accredited hospital, or a Network hospital previously approved by the committee.
DEA/CDS and state controlled substance registrations <ul style="list-style-type: none"> a. The DEA/CDS registration must be valid in the state(s) in which practitioner will be treating Members. Practitioners who see Members in more than one state must have a DEA/CDS registration for each state.
Malpractice insurance
Malpractice claims history
Board certification or highest level of medical training or education
Work history
State or Federal license sanctions or limitations
Medicare, Medicaid or FEHBP sanctions
National Practitioner Data Bank report
State Medicaid Exclusion Listing, if applicable

B. HDOs

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

[Recredentialing](#)

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

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

[Health Delivery Organizations](#)

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

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

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

[Ongoing Sanction Monitoring](#)

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

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

When a practitioner or HDO within the scope of credentialing has been identified by these sources, criteria will be used to assess the appropriate response.

[Appeals Process](#)

Anthem has established policies for monitoring and re-credentialing practitioners and HDOs who seek continued participation in one or more of Anthem's Networks or Plan Programs. Information reviewed during this activity may indicate that the professional conduct and competence standards are no longer being met, and Anthem may wish to terminate practitioners or HDOs. Anthem also seeks to treat Network practitioners and HDOs as well as those applying for participation fairly, and thus provides practitioners and HDOs with a process to appeal determinations terminating/denying participation in Anthem's Networks for professional competence and conduct reasons, or which would otherwise result in a report to the National Practitioner Data Bank ("NPDB"). Additionally, Anthem will permit practitioners and HDOs who have been refused initial participation the opportunity to correct any errors or omissions which may have led to such denial (informal/reconsideration only). It is the intent of Anthem to give practitioners and HDOs the opportunity to contest a termination of the practitioner's or HDO's participation in one or more of Anthem's Networks or Plan Programs or and those denials of request for initial participation which are reported to the NPDB that were based on professional competence and conduct considerations. Immediate

terminations may be imposed due to the practitioner's or HDO's license suspension, probation, or revocation, or if a practitioner or HDO has been sanctioned, debarred or excluded from the Medicare, Medicaid or FEHB programs, or has a criminal conviction, or Anthem's determination that the practitioner's or HDO's continued participating poses an imminent risk of harm to Members. Participating practitioners whose network participation has been terminated due to sanction, debarment or exclusion from the Medicare, Medicaid or FEHB are not eligible for Informal Review/Reconsideration or Formal Appeal.

Reporting Requirements

When Anthem takes a professional review action with respect to a practitioner's or HDO's participation in one or more of its Networks or Plan Programs, Anthem may have an obligation to report such to the NPDB, state licensing board and 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, the process set forth in the NPDB Guidebook will govern.

Anthem Credentialing Program Standards

I. Eligibility Criteria

Health care practitioners:

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

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

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

- A. For MDs, DOs, DPMs, and DMDs/DDSs practicing oral and maxillofacial surgery, 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 Foot and Ankle Surgery ("ABFAS"), American Board of Podiatric Medicine ("ABPM"), or American Board of Oral and Maxillofacial Surgery ("ABOMS")) in the clinical discipline for which they are applying.
- B. If not certified, MDs and DOs will be granted five years or a period of time consistent with ABMS or AOA board eligibility time limits, whatever is greater, after completion of their residency or fellowship training program to meet the board certification requirement.
- C. If not certified, DPMs will be granted five years after the completion of their residency to meet this requirement for the ABPM. Non-certified DPMs will be granted seven years after completion of their residency to meet this requirement for ABFAS
- D. Individuals no longer eligible for board certification are not eligible for continued exception to this requirement.
 1. As alternatives, MDs and DOs meeting any one of the following criteria will be viewed as meeting the education, training and certification requirement:
 - a. Previous board certification (as defined by one of the following: ABMS, AOA, RCPSC, CFPC, ABFAS, ABPM, or ABOMS) 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's 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"), Center for Improvement in Healthcare Quality ("CIHQ"), a Healthcare Facilities Accreditation Program ("HFAP") accredited hospital, or a Network hospital previously approved by the committee. Some clinical disciplines may function exclusively in the outpatient setting, and the CC may at its discretion deem hospital privileges not relevant to these specialties. Also, the organization of an increasing number of physician practice settings in selected fields is such that individual physicians may practice solely in either an outpatient or an inpatient setting. The CC will evaluate applications from practitioners in such practices without regard to hospital privileges. The expectation of these physicians would be that there is an appropriate referral arrangement with a Network practitioner to provide inpatient care.

II. Criteria for Selecting Practitioners

A. New Applicants (Credentialing)

1. Submission of a complete application and required attachments that must not contain intentional misrepresentations or omissions;
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 Members;
6. No current license action;
7. No history of licensing board action in any state;
8. No current federal sanction and no history of federal sanctions (per System for Award Management ("SAM"), OIG and OPM report nor on NPDB report);
9. Possess a current, valid, and unrestricted DEA/CDS registration for prescribing controlled substances, if applicable to his/her specialty in which he/she will treat Members. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members. Practitioners who treat Members in more than one state must have a valid DEA/CDS registration for each applicable state.

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

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

- ii. Initial applicants who possess a DEA certificate in a state other than the state in which they will be seeing Anthem's members will be notified of the need to obtain the additional DEA, unless the practitioner is delivering services in a telemedicine environment only and does not require a DEA or CDS registration in the additional location(s) where such telemedicine services may be rendered under federal or state law. If the applicant has applied for an additional DEA registration the credentialing process may proceed if all the following criteria are met:
 - a) It can be verified that the applicant's application is pending; and
 - b) The applicant has made an arrangement for an alternative provider to prescribe controlled substances until the additional DEA registration is obtained; and
 - c) The applicant agrees to notify Anthem upon receipt of the required DEA registration; and
 - d) Anthem will verify the appropriate DEA/CDS registration via standard sources; and
 - e) The applicant agrees that failure to provide the appropriate DEA registration within a 90 day timeframe will result in termination from the network.
 - iii. Office-based practitioners who voluntarily choose to have a DEA/CDS registration that does not include all Controlled Substance Schedules (for example, Schedule, II, III or IV), if that practitioner certifies the following:
 - a) controlled substances from these Schedules are not prescribed within his/her scope of practice; and
 - b) he/she must provide documentation that an arrangement exists for an alternative provider to prescribe controlled substances from these Schedules should it be clinically appropriate; and
 - c) DEA/CDS registration is or was not suspended, revoked, surrendered or encumbered for reasons other than those aforementioned.
10. No current hospital membership or privilege restrictions and no history of hospital membership or privileges restrictions;
 11. No history of or current use of illegal drugs or history of or current alcoholism;
 12. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field.
 13. No gap in work history greater than six (6) months in the past five (5) years with the exception of those gaps related to parental leave or immigration where twelve (12) month gaps will be acceptable. No history of criminal/felony convictions or a plea of no contest;
 14. A minimum of the past ten (10) years of malpractice case history is reviewed.
 15. Meets Credentialing Standards for education/training for the specialty(ies) in which practitioner wants to be listed in Anthem's Network directory as designated on the application. This includes board certification requirements or alternative criteria for MDs and DOs and board certification criteria for DPMs, and oral and maxillofacial surgeons;
 16. No involuntary terminations from an HMO or PPO;
 17. No "yes" answers to attestation/disclosure questions on the application form with the exception of the following:
 - a. investment or business interest in ancillary services, equipment or supplies;
 - b. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - c. voluntary surrender of state license related to relocation or nonuse of said license;

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

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

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. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or FEHBP. If, once a Practitioner participates in Anthem's programs or provider Network(s), federal sanction, debarment or exclusion from the Medicare, Medicaid or FEHBP programs occurs, at the time of identification, the Practitioner will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Anthem's other credentialed provider Network(s).
- 4. Current, valid, unrestricted, unencumbered, unprobated license to practice in each state in which the practitioner provides care to Members;
- 5. No new history of licensing board reprimand since prior credentialing review;
- 6. *No current federal sanction and no new (since prior credentialing review) history of federal sanctions (per SAM, OIG and OPM Reports or on NPDB report);
- 7. Current DEA/CDS registration and/or state controlled substance certification without new (since prior credentialing review) history of or current restrictions;
- 8. No current hospital membership or privilege restrictions and no new (since prior credentialing review) history of hospital membership or privilege restrictions; OR for practitioners in a specialty defined as requiring hospital privileges who practice solely in the outpatient setting there exists a defined referral relationship with a Network practitioner of similar specialty at a Network HDO who provides inpatient care to Members needing hospitalization;
- 9. No new (since previous credentialing review) history of or current use of illegal drugs or alcoholism;
- 10. No impairment or other condition which would negatively impact the ability to perform the essential functions in their professional field;
- 11. No new (since previous credentialing review) history of criminal/felony convictions, including a plea of no contest;
- 12. 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.
- 13. No new (since previous credentialing review) involuntary terminations from an HMO or PPO;
- 14. No new (since previous credentialing review) "yes" answers on attestation/disclosure questions with exceptions of the following:

- a. voluntary resignation from a hospital or organization related to practice relocation or facility utilization;
 - b. voluntary surrender of state license related to relocation or nonuse of said license;
 - c. an NPDB report of a malpractice settlement or any report of a malpractice settlement that does not meet the threshold criteria;
 - d. 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);
 - e. 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;
 - f. actions taken by a hospital against a practitioner's privileges related solely to the failure to complete medical records in a timely fashion;
 - g. history of a licensing board, hospital or other professional entity investigation that was closed without any action or sanction.
15. No QI data or other performance data including complaints above the set threshold.
16. Recredentialed at least every three (3) years to assess the practitioner's continued compliance with Anthem standards.

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

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

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

- 1. Licensed Clinical Social Workers ("LCSW") or other master level social work license type:
 - a. Master or doctoral degree in social work with emphasis in clinical social work from a program accredited by the Council on Social Work Education ("CSWE") or the Canadian Association on Social Work Education ("CASWE").
 - b. Program must have been accredited within three (3) years of the time the practitioner graduated.
 - c. Full accreditation is required, candidacy programs will not be considered.
 - d. If master's level degree does not meet criteria and practitioner obtained PhD degree 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 American Psychological Association ("APA") or be regionally accredited by the Council for Higher Education Accreditation ("CHEA"). In addition, a doctor of social work from an institution with at least regional accreditation from the CHEA will be viewed as acceptable.
- 2. Licensed professional counselor ("LPC") and marriage and family therapist ("MFT") or other master level license type:
 - a. Master's or doctoral degree in counseling, marital and family therapy, psychology, counseling psychology, counseling with an emphasis in marriage, family and child counseling or an allied mental field. Master or doctoral degrees in education are acceptable with one of the fields of study above.
 - b. Master or doctoral degrees in divinity do not meet criteria as a related field of study.
 - c. Graduate school must be accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, Council for Accreditation of Counseling and Related Educational Programs ("CACREP"), or Commission on Accreditation for Marriage and Family Therapy Education ("COAMFTE") listings. The institution must have been accredited within three (3) years of the time the practitioner graduated.

- d. Practitioners with PhD training as a clinical psychologist can be reviewed. To meet criteria this doctoral program must either be accredited by the APA or be regionally accredited by the CHEA. A Practitioner with a doctoral degree in one of the fields of study noted will be viewed as acceptable if the institution granting the degree has regional accreditation from the CHEA and;
 - e. Licensure to practice independently.
3. Clinical nurse specialist/psychiatric and mental health nurse practitioner:
- a. Master's degree in nursing with specialization in adult or child/adolescent psychiatric and mental health nursing. Graduate school must be accredited from an institution accredited by one of the Regional Institutional Accrediting Bodies within three (3) years of the time of the practitioner's graduation.
 - b. Registered Nurse license and any additional licensure as an Advanced Practice Nurse/Certified Nurse Specialist/Adult Psychiatric Nursing or other license or certification as dictated by the appropriate State(s) Board of Registered Nursing, if applicable.
 - c. Certification by the American Nurses Association ("ANA") in psychiatric nursing. This may be any of the following types: Clinical Nurse Specialist in Child or Adult Psychiatric Nursing, Psychiatric and Mental Health Nurse Practitioner, or Family Psychiatric and Mental Health Nurse Practitioner.
 - d. Valid, current, unrestricted DEA/CDS registration, where applicable with appropriate supervision/consultation by a Network practitioner as applicable by the state licensing board. For those who possess a DEA registration, the appropriate CDS registration is required. The DEA/CDS registration must be valid in the state(s) in which the practitioner will be treating Members.
4. Clinical Psychologists:
- a. Valid state clinical psychologist license.
 - b. Doctoral degree in clinical or counseling, psychology or other applicable field of study from an institution accredited by the APA within three (3) years of the time of the practitioner's graduation.
 - c. Education/Training considered as eligible for an exception is a practitioner whose doctoral degree is not from an APA accredited institution, but who is listed in the National Register of Health Service Providers in Psychology or is a Diplomat of the American Board of Professional Psychology.
 - d. Master's level therapists in good standing in the Network, who upgrade their license to clinical psychologist as a result of further training, will be allowed to continue in the Network and will not be subject to the above education criteria.
5. Clinical Neuropsychologist:
- a. Must meet all the criteria for a clinical psychologist listed in C.4 above and be Board certified by either the American Board of Professional Neuropsychology ("ABPN") or American Board of Clinical Neuropsychology ("ABCN").
 - b. A practitioner credentialed by the National Register of Health Service Providers in Psychology with an area of expertise in neuropsychology may be considered.
 - c. Clinical neuropsychologists who are not Board certified, nor listed in the National Register, will require CC review. These practitioners must have appropriate training and/or experience in neuropsychology as evidenced by one or more of the following:
 - i. Transcript of applicable pre-doctoral training, OR
 - ii. Documentation of applicable formal one (1) year post-doctoral training (participation in CEU training alone would not be considered adequate), OR
 - iii. Letters from supervisors in clinical neuropsychology (including number of hours per week), OR

- iv. Minimum of five (5) years' experience practicing neuropsychology at least ten (10) hours per week.
- 6. Licensed Psychoanalysts:
 - a. Applies only to Practitioners in states that license psychoanalysts.
 - b. Practitioners will be credentialed as a licensed psychoanalyst if they are not otherwise credentialed as a practitioner type detailed in Credentialing Policy (e.g. psychiatrist, clinical psychologist, licensed clinical social worker).
 - c. Practitioner must possess a valid psychoanalysis state license.
 - i. Practitioner shall possess a master's or higher degree from a program accredited by one of the Regional Institutional Accrediting Bodies and may be verified from the Accredited Institutions of Post-Secondary Education, APA, CACREP, or the COAMFTE listings. The institution must have been accredited within 3 years of the time the Practitioner graduates.
 - ii. Completion of a program in psychoanalysis that is registered by the licensing state as licensure qualifying; or accredited by the American Board for Accreditation in Psychoanalysis (ABAP) or another acceptable accrediting agency; or determined by the licensing state to be the substantial equivalent of such a registered or accredited program.
 - a) A program located outside the United States and its territories may be used to satisfy the psychoanalytic study requirement if the licensing state determines the following: it prepares individuals for the professional practice of psychoanalysis; and is recognized by the appropriate civil authorities of that jurisdiction; and can be appropriately verified; and is determined by the licensing state to be the substantial equivalent of an acceptable registered licensure qualifying or accredited program.
 - b) Meet minimum supervised experience requirement for licensure as a psychoanalyst as determined by the licensing state.
 - c) Meet examination requirements for licensure as determined by the licensing state.
- D. Additional Participation Criteria and Exceptions for Nurse Practitioners, Certified Nurse Midwives, Physicians Assistants (Non Physician) Credentialing.
 - 1. Process, requirements and Verification – Nurse Practitioners:
 - a. The nurse practitioner applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
 - b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a Registered Nurse, and subsequent additional education leading to licensure as a NP. Verification of this will occur either via verification of the licensure status from the state licensing agency provided that that agency verifies the education or from the certification board if that board provides documentation that it performs primary verification of the professional education and training. If the licensing agency or certification board does not verify highest level of education, the education will be primary source verified in accordance with policy.
 - c. The license status must be that of NP as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicants whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
 - d. If the NP has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in

force adverse actions against the DEA, the applicant will be notified of this and the applicant will be administratively denied.

- e. All NP applicants will be certified in the area which reflects their scope of practice by any one of the following:
 - i. Certification program of the American Nurse Credentialing Center (www.nursecredentialing.org), a subsidiary of the American Nursing Association (http://www.nursingcertification.org/exam_programs.htm); or
 - ii. American Academy of Nurse Practitioners – Certification Program (www.aanpcertification.org); or
 - iii. National Certification Corporation (<http://www.nccwebsite.org>); or
 - iv. Pediatric Nurse Certification Board (PNCB) Certified Pediatric Nurse Practitioner – (note: CPN – certified pediatric nurse is not a nurse practitioner) (<http://www.pncb.org/ptistore/control/exams/ac/progs>); OR
 - v. Oncology Nursing Certification Corporation (ONCC) – Advanced Oncology Certified Nurse Practitioner (AOCNP®) – ONLY (<http://oncc.org>);
 - vi. American Association of Critical Care Nurses (<https://www.aacn.org/certification/verify-certification>) ACNPC – Adult Care Nurse Practitioner; ACNPC-AG – Adult Gerontology Acute Care. This certification must be active and primary source verified.

This certification must be active and primary source verified. If the state licensing board primary sources verifies this certification as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if his/her certification has expired, the application will be submitted for individual review.

- f. If the NP has hospital privileges, they must have hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee. Information regarding history of any actions taken against any hospital privileges held by the NP will be obtained. Any adverse action against any hospital privileges will trigger a level II review.
 - g. The NP applicant will undergo the standard credentialing processes outlined in Anthem’s Credentialing Policies. NPs are subject to all the requirements outlined in these Credentialing Policies including (but not limited to): the requirement for Committee review of Level II files for failure to meet predetermined criteria, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
 - h. Upon completion of the credentialing process, the NP may be listed in Anthem’s provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
 - i. NPs will be clearly identified as such:
 - i. On the credentialing file;
 - ii. At presentation to the Credentialing Committee; and
 - iii. On notification to Network Services and to the provider database.
2. Process, Requirements and Verifications – Certified Nurse Midwives:
- a. The Certified Nurse Midwife (CNM) applicant will submit the appropriate application and supporting documents as required of any other Practitioner with the exception of differing information regarding education, training and board certification.
 - b. The required educational/training will be at a minimum that required for licensure as a Registered Nurse with subsequent additional training for licensure as a Certified Nurse Midwife by the appropriate licensing body. Verification of this education and training will occur either via primary source verification of the license, provided that state licensing agency performs verification of the education, or from the certification board if that board provides documentation that it performs primary verification of the

professional education and training. If the state licensing agency or the certification board does not verify education, the education will be primary source verified in accordance with policy.

- c. The license status must be that of CNM as verified via primary source from the appropriate state licensing agency. Additionally, this license must be active, unencumbered, unrestricted and not subject to probation, terms or conditions. Any applicant whose licensure status does not meet these criteria, or who have in force adverse actions regarding Medicare or Medicaid will be notified of this and the applicant will be administratively denied.
- d. If the CNM has prescriptive authority, which allows the prescription of scheduled drugs, their DEA and/or state certificate of prescriptive authority information will be requested and primary source verified via normal Anthem procedures. If there are in force adverse actions against the DEA, the applicant will be notified and the applicant will be administratively denied.
- e. All CNM applicants will be certified by either:
 - i. The National Certification Corporation for Ob/Gyn and Neonatal Nursing; or
 - ii. The American Midwifery Certification Board, previously known as the American College of Nurse Midwives.

This certification must be active and primary source verified. If the state licensing board primary source verifies one of these certifications as a requirement for licensure, additional verification by Anthem is not required. If the applicant is not certified or if their certification has expired, the application will be submitted for individual review by the geographic Credentialing Committee.

- f. If the CNM has hospital privileges, they must have unrestricted hospital privileges at a CIHQ, TJC, NIAHO, or HFAP accredited hospital, or a network hospital previously approved by the committee or in the absence of such privileges, must not raise a reasonable suspicion of future substandard professional conduct or competence. Information regarding history of any actions taken against any hospital privileges held by the CNM will be obtained. Any history of any adverse action taken by any hospital will trigger a Level II review. Should the CNM provide only outpatient care, an acceptable admitting arrangement via the collaborative practice agreement must be in place with a participating OB/Gyn.
- g. The CNM applicant will undergo the standard credentialing process outlined in Anthem's Credentialing Policies. CNMs are subject to all the requirements of these Credentialing Policies including (but not limited to): the requirement for Committee review for Level II applicants, re-credentialing every three years, and continuous sanction and performance monitoring upon participation in the network.
- h. Upon completion of the credentialing process, the CNM may be listed in Anthem's provider directories. As with all providers, this listing will accurately reflect their specific licensure designation and these providers will be subject to the audit process.
- i. CNMs will be clearly identified as such:
 - i. On the credentialing file;
 - ii. At presentation to the Credentialing Committee; and
 - iii. On notification to Network Services and to the provider database.

3. Process, Requirements and Verifications – Physician's Assistants (PA):

- a. The PA applicant will submit the appropriate application and supporting documents as required of any other Practitioners with the exception of differing information regarding education/training and board certification.
- b. The required education/training will be, at a minimum, the completion of an education program leading to licensure as a PA. Verification of this will occur via verification of the licensure status from the state licensing agency provided that that agency verifies the education. If the state licensing agency does not verify education, the education will be primary source verified in accordance with policy.

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

III. HDO Eligibility Criteria

All HDOs must be accredited by an appropriate, recognized accrediting body or in the absence of such accreditation, Anthem may evaluate the most recent site survey by Medicare, the appropriate state oversight agency, or site survey performed by a designated independent external entity within the past 36 months. If a HDO has satellite facilities that follow the same policy and procedures, Anthem may limit site visits to the main facility. Non-accredited HDOs are subject to individual review by the CC and will be considered for Member 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 recertified 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 Members. The license must be in good standing with no sanctions.
2. Valid and current Medicare certification.
3. Must not be currently federally sanctioned, debarred or excluded from participation in any of the following programs; Medicare, Medicaid or the FEHBP. Note: If, once an HDO participates in Anthem's programs or provider Network(s), exclusion from Medicare, Medicaid

or FEHBP occurs, at the time of identification, the HDO will become immediately ineligible for participation in the applicable government programs or provider Network(s) as well as Anthem's other credentialed provider Network(s).

4. Liability insurance acceptable to Anthem.
5. If not appropriately accredited, HDO must submit a copy of its CMS, state site or a designated independent external entity survey for review by the CC to determine if Anthem's quality and certification criteria standards have been met.

B. Additional Participation Criteria for HDO by Provider Type:

HDO Type and Anthem Approved Accrediting Agent(s)

Medical Facilities

Facility Type (MEDICAL CARE)	Acceptable Accrediting Agencies
Acute Care Hospital	CICQ, CTEAM, DNV/NIAHO, HFAP, TJC
Ambulatory Surgical Centers	AAAASF, AAAHC, AAPSF, HFAP, IMQ, TJC
Birthing Center	AAAHC, CABC, TJC
Home Health Care Agencies (HHA)	ACHC, CHAP, CTEAM, DNV/NIAHO, TJC
Home Infusion Therapy (HIT)	ACHC, CHAP, CTEAM, HQAA, TJC
Skilled Nursing Facilities/Nursing Homes	BOC INT'L, CARF, TJC

Behavioral Health

Facility Type (BEHAVIORAL HEALTH CARE)	Acceptable Accrediting Agencies
Acute Care Hospital—Psychiatric Disorders	CTEAM, DNV/NIAHO, TJC, HFAP
Adult Family Care Homes (AFCH)	ACHC, TJC
Adult Foster Care	ACHC, TJC
Community Mental Health Centers (CMHC)	AAAHC, CARF, CHAP, COA, TJC
Crisis Stabilization Unit	TJC
Intensive Family Intervention Services	CARF
Intensive Outpatient – Mental Health and/or Substance Abuse	ACHC, CARF, COA, DNV/NIAHO, TJC
Outpatient Mental Health Clinic	CARF, CHAP, COA, HFAP, TJC
Partial Hospitalization/Day Treatment—Psychiatric Disorders and/or Substance Abuse	CARF, DNV/NIAHO, HFAP, TJC
Residential Treatment Centers (RTC) – Psychiatric Disorders and/or Substance Abuse	CARF, COA, DNV/NIAHO, HFAP, TJC

Rehabilitation

Facility Type (Behavioral Health Care)	Acceptable Accrediting Agencies
Acute Inpatient Hospital – Detoxification Only Facilities	CTEAM, DNV/NIAHO, HFAP, TJC
Behavioral Health Ambulatory Detox	CARF, TJC
Methadone Maintenance Clinic	CARF, COA, TJC
Outpatient Substance Abuse Clinics	CARF, TJC

Standards of Participation

[Standards of Participation](#)

IMPORTANT: Providers must be approved by Anthem; (credentialing approved and contracting completed) before providers can begin providing covered healthcare services to Anthem Members as a Network/Participating Provider. When fully approved to participate in Anthem's Networks a welcome letter is mailed.

Contracting Process

- Step 1** Submit the Provide Maintenance Form to the Provider Contract Administration department; and Anthem will send an appropriate contracting packet.

Providers are required to submit their application via CAQH. If you do not have a CAQH number, please fax the completed CAQH registration form to (877) 798-1015.

IMPORTANT NOTE: We will not accept any other forms until the application has been completed on CAQH. Status must indicate either “**Initial Application Complete**” or “**Reattestation**”.

- Step 2** Complete all forms included in the packet and submit to:
Anthem Blue Cross and Blue Shield
1831 Chestnut Street
St. Louis, MO 63103
Attn: Provider Contract Administration
Mail Route: MOM904-S442
- Step 3** An e-mail notification will be sent to you confirming receipt of your completed contracting packet.
IMPORTANT: Providers must receive a network participation approval letter from Contract Administration prior to delivering healthcare services to Anthem Members. Once approved, a notification letter will be sent regarding your participation.
- Step 4** Credentials Review
Provider credentials will be reviewed by the Anthem Credentialing Department. Credentials must be approved to participate in the Anthem provider networks. This **does not** complete the contracting process.
- Step 5** Contract Execution
When approved by the Credentials Committee, contract administration will review your executed contract.
- Step 6** System Loading
Your profile will be loaded into Anthem’s systems using the National Provider Identifier(s) (NPI) you provided.
- Step 7** Provider Notification
Upon completion of the above processes, you will receive a written notification of your approved network(s) participation status. A copy of your executed contract will be forwarded. **Please note:** upon receipt of this written notification, you can begin rendering healthcare services to Anthem Members.

The entire contracting process may take up to 60 business days from the date of receipt of a completed contracting packet.

[Professional Missouri Selection Standards](#)

1. The healthcare professional/provider must enter into the then current written provider agreement and abide by and comply with all terms and conditions of the provider agreement and fulfill all obligations imposed on the healthcare professional/provider under such provider agreement. Concurrent with Anthem’s periodic recredentialing, the healthcare professional/provider must enter into the then current written participation agreement.
2. The healthcare professional/provider who participates in the networks/programs of any other Missouri corporate affiliate in the Anthem family of companies must be in good standing with such affiliates, abiding by and complying with all terms and conditions of the affiliate’s provider agreement and fulfill all obligations imposed on the healthcare professional/provider under the affiliate’s such provider agreement.
3. The healthcare professional/provider’s primary office location must be located within the Anthem service area or within the approved counties contiguous to the Anthem service area.
4. The healthcare professional/provider must not be restricted from participating in one or more of Anthem’s programs or networks by an exclusive or other arrangement with any person or entity other than Anthem.
5. In certain geographical areas, the healthcare professional/provider may be required to participate in one or more of the Anthem programs or networks through an intermediary with whom Anthem has an exclusive or other restrictive arrangement.
6. Active hospital privileges must be maintained by the healthcare professional/provider with at least one or more of the network hospitals pertaining to Anthem’s specific programs or networks of interest,

where applicable. The healthcare professional/provider may also provide for hospital coverage by using the services of in-network hospital-based providers.

7. The healthcare professional/provider practice must not consist of a boutique, concierge, or retainer-type arrangement with its patients.
8. The healthcare professional/provider must not receive, give, provide, or condone any incentives or kickbacks, monetary or otherwise, in exchange for the referral of a covered person to other healthcare professionals or facilities.
9. The healthcare professional/provider must maintain professional liability insurance coverage, on a per occurrence basis, in the amount of \$500,000, and \$1,000,000 in the aggregate. The healthcare professional/provider is encouraged to maintain professional liability insurance coverage, on a per occurrence basis, in the amount of \$1,000,000, and \$3,000,000 in the aggregate.
10. If the healthcare professional is a primary care physician or OB/GYN, he or she must be available to treat patients at least twenty (20) hours per week unless there is a network need determined by the Director of Network Management.
11. The healthcare professional/provider must provide or arrange for twenty-four (24) hours, seven (7) days per week coverage for Members who participate in Anthem's programs/networks.
12. The healthcare professional/provider may be excluded from participation if the professional/provider's application or other information obtained as part of the application or review process:
 - a. is found to be incomplete,
 - b. contains unacceptable information,
 - c. is believed or determined to contain untrue, misrepresented, or fraudulent statements, or
 - d. contains information or is determined to be unacceptable by Anthem, for any reason(s) listed above, or for any other reason, including, without limitation, the following reasons:
 - i. the healthcare professional/provider's liability Claims history or outcomes of litigation raises questions regarding the care that may be provided by the healthcare professional/provider;
 - ii. the healthcare professional/provider's background raises questions regarding the ethical conduct of the healthcare professional/provider;
 - iii. the healthcare professional/provider's application was previously denied by Anthem or one of its affiliates within the past thirty-six (36) months;
 - iv. the healthcare professional/provider's provider agreement or participation under a provider agreement with Anthem was previously suspended, terminated, or non-renewed;
 - v. review of the healthcare professional/provider's practice indicates that the healthcare professional/provider practices, or provides services, in a manner that might unreasonably increase Anthem's cost of providing health care services to Members;
 - vi. the healthcare professional/provider is in or joining a professional practice or a professional group practice that is currently being investigated by the Special Investigations Unit and/or the Clinical Investigations Unit; or
 - vii. the healthcare professional/provider is in or joining a professional practice or a professional group practice that has demonstrated continued non-compliance with Anthem policies and procedures and/or the policies and procedures of any other Missouri corporate affiliate in the Anthem family of companies.

Participation in one or more of Anthem Blue Cross and Blue Shield's programs or networks is also subject to our credentialing policies and procedures.

Other Standards of Participation

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

Provider	Standards of Participation
Ambulance (Air & Ground)	Medicare Certification
Ambulatory Infusion Suites	TJC, CHAP or ACHC State & Pharmacy Licensure
Convenient Care Centers (CCCs)/Retail Health Clinics (RHC)	DNV/NIAHO, UCAOA, TJC
Durable Medical Equipment	TJC, CHAP, ACHC, (HQAA) Medicare Certification
Hearing Aid Supplier	State Licensure
Home Infusion Providers	TJC, CHAP or ACHC State & Pharmacy Licensure
Intermediate Care Facilities	CTEAM
Orthotics & Prosthetics	TJC, CHAP, The American Board for Certification in Orthotics, Prosthetics & Pedorthics (ABC) or Board of Certification/Accreditation (BOC) Ocularist: National Examining Board of Ocularists NEBO Preferred) Medicare Certification
Urgent Care Center (UCC)	AAAHC, IMQ, NUCCA (formerly ABUCM), TJC, UCAOA

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 Contract Administration.

Quality Improvement Program

[Quality Improvement Program Overview](#)

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

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

Information on Anthem’s QI Program and most current outcomes can be found on anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. Select the Health & Wellness tab at the top of the page. Select Quality Improvement and Standards, then the link titled **“Quality Improvement Program”**.

Goals and Objectives

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

- To develop and maintain a well-integrated system to continuously identify, measure, assess, and improve clinical and service quality outcomes through standardized and collaborative activities.
- To respond to the needs and expectations of internal and external customers by evaluating performance and taking action relative to meeting those needs and expectations including compliance with regulatory, and accreditation requirements, and policies and procedures.
- To promote processes that reduce medical errors and improve patient safety by implementing member-focused, provider, and safety initiatives.
- To identify the educational needs of Members, medical and behavioral healthcare providers and other health care professionals.
- For multicultural health strategies – to improve the health and health care of Anthem's multicultural Members.
- To help maximize health status, improve health outcomes, and reduce health care costs of Members through effective Case Management and Disease Management programs addressing complex care needs.

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

Quality and Safety of Clinical Care

- *Chronic Disease and Prevention:* Anthem focuses on Member and/or Provider/Facility outreach for chronic conditions like asthma, heart disease, diabetes, and COPD, and for preventive health services such as immunizations and cancer screenings. Improvements in these areas result in improved clinical measures such as HEDIS® (Healthcare Effectiveness Data and Information Set).
- *Behavioral Health Case Management:* A program designed to provide a comprehensive and integrated approach to early identification, appropriate treatment, intensive case management, and individualized recovery support for Members with complex, behavioral health conditions who are at risk for negative outcomes and high costs.
- *Community Health:* Anthem addresses public health priorities including behavioral health, cancer, diabetes, maternal/child health, obesity, patient safety, and smoking cessation by collaborating with key stakeholders in the industry. These focus areas are aligned with the Anthem Foundation's goals.
- *Disease Management:* The ConditionCare program is designed to help maximize health status, help improve health outcomes, and help reduce health care costs of Members diagnosed with Asthma (pediatric and adult), Diabetes (Type 1 and Type 2, pediatric and adult), Coronary Artery Disease (CAD), Heart Failure (HF) and Chronic Obstructive Pulmonary Disease (COPD). The Disease Management program was created and developed based on recent versions of nationally accepted evidence-based clinical practice guidelines. These guidelines are reviewed at least every two years, and program interventions and protocols are updated accordingly.
- *Health & Wellness:* Programs offer a seamless integration of preventive care, wellness, care management, coordination services and online and mobile tools to meet the needs of Members along the complete continuum of care. Programs include: MyHealth Coach (MHC), MyHealth Advantage (MHA), Neonatal Intensive Care Program (NICU), Worksite Wellness, and Healthy Lifestyles (HL) and Healthwise® Knowledge Base (HWKB)..

Service Quality

Anthem periodically surveys its Members, evaluates quality of care and service of network providers, and strives to provide excellent service to Members, Providers and Facilities. Anthem actively analyzes trends, takes action on opportunities recommending appropriate activities to address root causes.

Patient Safety

The strategic vision for patient safety for Members is to establish and maintain goals in advancing patient safety. This program is structured to align with the overall mission and national patient safety strategy. The goals are to work with physicians, hospitals, and other health care partners to reduce adverse drug events, health care associated conditions, hospital readmissions, and avoidable cost of care, as well as develop innovative programs to accelerate improvements in quality and safety. Priority areas include medication safety, radiation safety, surgical safety, infection control, patient protection, patient engagement, care management, and payment

innovation. These member- and provider-facing initiatives/activities are designed to meet regulatory and accreditation requirements, and consumer needs. Whenever possible, nationally endorsed clinical metrics are used to evaluate progress.

[Member Rights and Responsibilities](#)

The delivery of quality health care requires cooperation between Members, their Providers and Facilities and their health care benefit plans. One of the first steps is for Members, Providers and Facilities to understand member rights and responsibilities. Therefore, Anthem has adopted a Members' Rights and Responsibilities statement which can be accessed by going to [anthem.com](#), select **Providers** under Partner Login. Select **Find Resources in Your State**, and **Missouri**. Select the **Health & Wellness** tab, then the link titled "[Quality Improvement and Standards](#), and finally **Members Rights and Responsibilities**. Members or Providers who do not have access to the website can request copies by contacting Anthem. If Members need more information or would like to contact us, go to [anthem.com](#), select **Providers** under Partner Login, select **Contact Us**. Or Members can call the Member Services, and Providers can call the Provider Services number on the back of the Member ID card.

[Minor Conditions Not Covered in Emergency Department Setting](#)

Anthem has a policy in the Member's Certificate of Coverage which states that services for minor conditions will not be covered when treated in the hospital emergency department if more appropriate settings are available. The common symptoms that can be treated in less intensive settings can be found at [www.anthem.com/findurgentcare](#). Per this policy, should members choose to receive non-emergency care in the emergency department, they will be responsible for the charges incurred.

[Continuity and Coordination of Care](#)

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

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

[Continuity of Care/Transition of Care Program](#)

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

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

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

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

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

[Quality – In – Sights®: Hospital Incentive Program \(Q-HIP®\)](#)

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

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

- American College of Cardiology (ACC)

- 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 hospitals for all patient data – regardless of health plan carrier.

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

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

[Performance Data](#)

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

- **Reward Programs** – Pay for performance (P4P), pay for value (PFV), and other results-based reimbursement programs that tie Provider or Facility reimbursement to performance against a defined set of compliance metrics. Reimbursement models include but are not limited to total cost of care shared savings/risk programs, enhanced fee schedules, and episode bundled payment arrangements.
- **Recognition Programs** – Programs designed to transparently identify high value Providers and Facilities and make that information available to consumers, employers, peer practitioners and other healthcare stakeholders.

Overview of HEDIS®

HEDIS (*Healthcare Effectiveness Data and Information Set*) is a set of standardized performance measures used to compare the performance of managed care plans and physicians based on value rather than cost. HEDIS is coordinated and administered by NCQA and is one of the most widely used sets of health care performance measures in the United States. Anthem's HEDIS Quality Team is responsible for collecting clinical information from Provider offices in accordance with HEDIS specifications. Record requests to Provider offices begin in early February and Anthem requests that the records be returned within 5 business days to allow time to abstract the records and request additional information from other Providers, if needed. Health plans use HEDIS data to encourage their contracted providers to make improvements in the quality of care and service they provide. Employers and consumers use HEDIS data to help them select the best health plan for their needs.

More information on HEDIS, can be found online at anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list.. Select the **Health and Wellness** tab at the top of the page. Select the **Quality Improvement and Standards** link, then scroll down to **HEDIS Information**.

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

Overview of CAHPS

CAHPS® (Consumer Assessment of Healthcare Providers and Systems) surveys represent an effort to accurately and reliably capture key information from Anthem's Members about their experiences with Anthem's health plans

in the past year. This includes the Member's access to medical care and the quality of the services provided by Anthem's network of Providers.

Anthem analyzes this feedback to identify issues causing Member dissatisfaction and works to develop effective interventions to address them. Anthem takes this survey feedback very seriously.

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

Results of these surveys are shared with Providers annually via "Network Update" newsletters, so they have an opportunity to learn how Anthem Members feel about the services provided. Anthem encourages Providers to assess their own practice to identify opportunities to improve patients' access to care and improve interpersonal skills to make the patient care experience a more positive one. To access the annual "Network Update" visit anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider Home page, select "Network Update (Provider Newsletter)" under Communications and Updates

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

Clinical Practice Guidelines

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

Providers can access the up-to-date listing of the medical, preventive and behavioral health guidelines through the Internet. To access the guidelines, go to the "Provider" home page at anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider Home page, under the Health and Wellness tab select or scroll to the practice guidelines, then select the link titled "[Clinical Practice Guidelines](#)".

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

Preventive Health Guidelines

Anthem considers prevention to be an important component of health care. Anthem develops preventive health guidelines in accordance with recommendations made by nationally recognized organizations and societies such as the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), the Advisory Committee on Immunizations Practices (ACIP), the American College of Obstetrics and Gynecology (ACOG) and the United States Preventive Services Task Force (USPSTF). The above organizations make recommendations based on reasonable medical evidence.

We review the guidelines annually for content accuracy, current primary sources, new technological advances and recent medical research and make appropriate changes based on this review of the recommendations and/or preventive health mandates. We encourage physicians to utilize these guidelines to improve the health of our Members.

The current guidelines are available on our website. To access the guidelines, go to anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider Home page, On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider Home page, under the Health and Wellness tab select or scroll to the practice guidelines, then select the "[Preventive Health Guidelines](#)".

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

Medical Record Standards

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

For more information on Medical Record standards, please go to anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. On the Provider home page under the Health and Wellness tab, choose Quality Improvement and Standards, and then scroll down to “Medical Record Review”.

Multicultural Health

Multicultural Health Overview

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

1. Monitors the quality of health care for actionable health and health care disparities trends
 - a. Identifies clinical and geographic areas exhibiting health and health care disparities and designs appropriate interventions to help close the disparity gaps
 - b. Establishes baseline data and measures/evaluates the results of program interventions
 - c. Supports Member access to equitable treatment, standards of care and services based on their Plan benefits
2. Promotes Culturally and Linguistically Appropriate Services (“CLAS”)
 - a. Offers education, tools and subject matter expertise to Providers and Facilities that may help them achieve the shared goal of providing quality care and service equally to their patients
 - b. Facilitates cultural competency of Anthem associates to meet the Members’ needs for culturally sensitive, linguistically appropriate care and service
 - c. Offers education, tools and subject matter expertise to Members that may help them improve their health literacy, allowing better communication with their doctors and Anthem about their health care and service
3. Develops programs to help improve health status and outcomes
 - a. Promotes consumer-centered care that addresses the Members’ values, needs and preferences in reaching optimal health care and outcomes standards
 - b. Supports communities in which Anthem does business with cultural and linguistic programs and services
 - c. Collaborates with other industry and government efforts to help reduce and eliminate health disparities

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

Anthem Innovation

Asthma & Me App

Are you looking for innovative ways to engage your patients with asthma? Show them the pathophysiology of asthma. The Asthma & Me app is a valuable, free support tool in the care of this pervasive chronic condition. The app uses face detection technology along with augmented reality to simulate a diseased airway.

- When the camera on the mobile device is aimed at the patient’s face, an animation of the lungs is overlaid and a short video illustrating the physiology of an asthma attack is produced and recorded.
- The video can be used to facilitate discussion with the patient about what occurs during an asthma attack – airway inflammation, bronchiole constriction, and mucus production.

- The video can be saved and shared via social media or email.

The app is currently available in three languages: English, Spanish, and Tagalog. The language is selected based on the patient's smartphone or tablet settings.

The Asthma & Me app can be accessed at www.MyDiversePatients.com using your smartphone, tablet, or computer. The app supplements the "Moving Toward Equity in Asthma Care" online provider CME experience, which is also available on the site as well as www.anthem.com/asthma.equity.

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

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

A "Resources" section contains additional information on asthma disparities.

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

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

The course is accessible from any mobile device, laptop, or desktop computer. Users must have access to Internet Explorer (9 or later), Google Chrome (38 or later), Safari (5 or later), Mozilla Firefox (32 or later).

The enduring material activity, Moving Toward Equity in Asthma Care, has been reviewed and is acceptable for up to 1 Prescribed credit by the American Academy of Family Physicians. Term of approval begins September 28, 2017. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Additional Learning Opportunities

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

[Cultural competency training available on anthem.com](http://www.anthem.com)

Creating an LGBT-Friendly Practice

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

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

The course is accessible from any mobile device, laptop, or desktop computer. Users must have access to Internet Explorer (9 or later), Google Chrome (38 or later), Safari (5 or later), Mozilla Firefox (32 or later).

The enduring material activity, Creating an LGBT-Friendly Practice, has been reviewed and is acceptable for up to 1 Prescribed credit by the American Academy of Family Physicians. Term of approval begins January 1, 2018. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Reducing Health Care Stereotype Threat (“HCST”): Assuring your diverse patients they are not being judged due to their race/ethnicity

Your diverse patients may feel threatened of being personally reduced to group stereotypes. Their fear of being prejudged or stigmatized based on phenotype may be omnipresent throughout their life journeys and may be present during health care interactions with you or your team. A perceived health care stereotype threat is not the same as discrimination. Instead, it is a situational, psychosocial phenomenon that may contribute to disparities.

As a trusted health care Provider, you can make a difference. Find out how to recognize when your patients may be experiencing this threat. Then explore how to foster a threat-safe environment with practical shifts you can make today.

Visit the Provider pages online at www.anthem.com/HCST for free 24/7 access to the experience-either via your computer, tablet or smartphone. You will better understand Health Care Stereotype Threat (HCST) and its implications for multicultural patient groups and also learn how to recognize when your patients may be experiencing HCST. In addition, you will learn the benefits of reducing HCST to both your patients and your practice. The course is approved for 1 AAFP Prescribed credit, which is the equivalent to AMA PRA Category 1 Credit™.

The course is accessible from any mobile device, laptop, or desktop computer. Users must have access to Internet Explorer (9 or later), Google Chrome (38 or later), Safari (5 or later), Mozilla Firefox (32 or later).

The enduring material activity, Health Care Stereotype Threat, has been reviewed and is acceptable for up to 1 Prescribed credit by the American Academy of Family Physicians. Term of approval begins October 31, 2017. Term of approval is for one year from this date. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

Medication Adherence

It can be challenging when your patient doesn't follow your prescribed treatment plan. About 50% of patients in the U.S. stop taking medications within one year of being prescribed, and for non-adherent patients with chronic illness, hospital admission rates increase by up to 69% 1

Did you know:

- Medication adherence barriers exist in many patients and it is important to recognize that some of these barriers may be unique to a patient's racial or ethnic background.
- You can assist your patients in recognizing their own personal barriers to increase awareness of factors that lead to non-adherence.

Go to “Medication Adherence” on www.MyDiversePatients.com to see what your patients might be thinking while you're prescribing treatment and how you can help address medication adherence barriers.

1 Center for Disease Control and Prevention. (2017, February 1). *Overcoming Barriers to Medication Adherence for Chronic Conditions*. Retrieved from <https://www.cdc.gov/cdcgrandrounds/archives/2017/february2017.htm>.

Like you, Anthem strives to meet the needs of our diverse membership and upholds access to consistently high quality standards across our networks. We believe that by offering our Providers and Facilities these types of experiences, we can help keep all our Members healthy. In addition, these online experiences reinforce our commitment to equality for our diverse Members as referenced in our Provider and Facility contractual non-discrimination provisions.

A website to support your diverse patient panel

Mydiversepatients.com

Features robust resources for Providers to help support addressing racial and ethnic disparities in health and health care:

- CME learning experiences about disparities, potential contributing factors, and opportunities for Providers to enhance care.
- Real-life stories about diverse patients and the unique challenges they face.
- Tips and techniques for working with your diverse patients to promote improvement in health outcomes.

Member Health and Wellness Programs

Anthem seeks to improve the lives of the Members we serve. Anthem provides a unique blend of health and wellness programs to help Members reach their total well-being goals. A quick overview of the programs and services Anthem offers is available [online](#).

Centers of Medical Excellence

[Centers of Medical Excellence](#)

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

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

For both the BDC and Anthem CME programs, selection criteria are designed to evaluate overall quality, providing a comprehensive view of how the Facility delivers specialty care. More information on our programs can be accessed at [anthem.com](#), select **Providers** under Partner Login. On the Provider landing page, choose **Find Resources for Your State** and pick your state from the list. Select the **Health & Wellness** tab at the top of the page, and select [Centers of Medical Excellence](#).

[Transplant](#)

- Blue Distinction Centers for Transplant™ (“BDCT”) was launched in 2006.
- More than 115, 082 people in the United States were waiting for a lifesaving organ transplant from one of the nation’s more than 140 transplant programs in 2017. There were nearly 34,800 organ transplants in 2017. This was the fifth consecutive record-breaking year.
- Blue Distinction Centers and Blue Distinction Centers+ for Transplants have demonstrated their commitment to quality care, resulting in better overall outcomes for transplant patients. Each Facility meets stringent clinical criteria, established in collaboration with expert physicians’ and medical organizations’ recommendations**, including the Center for International Blood and Marrow Transplant Research (“CIBMTR”), the Scientific Registry of Transplant Recipients (“SRTR”) and the Foundation for the Accreditation of Cellular Therapy (“FACT”), and is subject to periodic re-evaluation as criteria continue to evolve. Both Blue Distinction Centers and Blue Distinction Centers+ for Transplants help simplify the administrative process involved in this complex care so that patients, their families, and physicians can focus on the medical issues.
- Hospitals receiving the Blue Distinction Center+ for Transplants designation have met the Blue Distinction Centers’ standards for quality while also demonstrating better cost-efficiency relative to their peers.

- The Anthem (CME) Transplant Network is a wrap-around network to the BDCT program and offers Members access to an additional 60 transplant facilities. When BDCT and Anthem CME are combined, Members have access to 300 transplant specific programs for heart, lung, combined heart/lung, liver, pancreas, combined kidney/pancreas, kidney and bone marrow/stem cell transplant.

Cardiac Care

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

Bariatric Surgery

- Blue Distinction Centers for Bariatric Surgery® launched in 2008
- According to the National Center for Health Statistics report released in November 2015: Prevalence of Obesity among Adults and Youth has grown to more than one-third (36.5%) of U.S. adults which have been diagnosed with obesity, and 32.3% for young adults aged 20-39. Obesity-related conditions include heart disease, stroke, type 2 diabetes and certain types of cancer, which are some of the leading causes of preventable death.
- Blue Distinction Centers for Bariatric Surgery have demonstrated their commitment to quality care, resulting in better overall outcomes for bariatric patients. Each facility meets stringent clinical criteria, developed in collaboration with expert physicians and medical organizations, including the American Society for Metabolic and Bariatric Surgery (ASMBS) and the American College of Surgeons (ACS), and is subject to periodic re-evaluation as criteria continue to evolve.
- The 2017 Blue Distinction Centers for Bariatric Surgery program uses updated Metabolic and Bariatric Surgery Accreditation and Quality Improvement Program (“MBSAQIP”) accreditation levels, which focus on site of service. With this design change, each facility can apply to achieve the BDC or BDC+ designation, as either a Comprehensive Center (including outpatient capability) or an Ambulatory Surgery Center (“ASC”).

Cancer Care

- Blue Distinction Centers for Cancer Care is a new national designation program that recognizes physicians, physician practices, cancer centers, and hospitals for their efforts in coordinating all types of cancer care. This program incorporates patient-centered and data-driven practices, to coordinate care better and to improve quality of care and safety, as well as affordability. Providers in this Program are paid under a provider agreement with their local BCBS Plan that has value-based reimbursement, rather than traditional fee-for-service, so they must perform against both quality and cost outcome targets in order to receive incentives and rewards for better health outcomes.
- Designations will be awarded on an ongoing basis, and the program will continue to expand in the future.

Spine Surgery

- Blue Distinction Centers for Spine Surgery® launched in November 2009. Studies confirm that as many as eight out of 10 Americans suffer from some sort of back pain. Many ways to treat back pain are available, and your doctor can guide you toward the most appropriate recommendation for your situation. For those with severe and/or chronic back pain, spine surgery may be a treatment option.
- Research confirms that hospitals designated as Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery have fewer complications and fewer hospital readmissions than non-designated hospitals. Blue Distinction Centers+ for Spine Surgery also deliver care more efficiently than their peers.

- Blue Distinction Centers and Blue Distinction Centers+ for Spine Surgery provide comprehensive inpatient spine surgery services, including discectomy, fusion and decompression procedures.
- To date, we have designated hospitals in the majority of states across the U.S.

[Knee and Hip Replacement](#)

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

[Maternity Care](#)

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

[Ventricular Assist Devices](#)

- Anthem's Center of Medical Excellence Ventricular Assist Device (VAD), small implantable pumps that assist the heart by pumping blood in the circulatory system of individuals with end-stage heart failure, launched in 2017.
- According to the Centers for Disease Control and Prevention Heart failure reports that about 5.7 million adults in the United States have heart failures a major public health problem associated with significant hospital admission rates, mortality, and costly health care services.
- Based on registry data, >15,000 left ventricular assist devices (LVADs) were implanted from June 2006 to December 2014. An estimated 3000+ VADs will be implanted worldwide this year, but the volume is expected to increase as newer, smaller devices receive regulatory approval, clinical indications slowly expand and the continued increase in centers certified to place these devices.

Member Grievance and Appeal Process

To help ensure that Members' rights are protected, all Anthem Members are entitled to a complaints and appeals process.

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

[Complaints](#)

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

- Anthem's Member services department logs oral and written complaints into a tracking system, research the issue, if appropriate, and responds to the Member.
- Anthem monitors Member services complaint response time to promote timely resolutions of Member complaints.

[Appeals](#)

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

- Anthem then determines whether to reverse or uphold the original decision.
- Following the determination, Anthem sends the Member a written notification of the appeal determination and the appeal is closed.
- A Member is advised of any additional appeal rights available to him/her.
- An external appeal is also available to the Member in some circumstances when the internal appeals process is exhausted without resolution to the Member's satisfaction.

Quality of Care Issues

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

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

Provider and Facility Complaint and Appeals Process

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

Timeframes for Submitting Complaints and Appeals

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

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

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

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

How Special Complaints and Appeals are Handled

Certain types of complaints or appeals are handled by specific Anthem departments and may follow different policies and procedures.

The following is a brief summary of some of the special complaint and appeal procedures.

Member Complaints and Appeals

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

Network Participation Appeals

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

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

[For More Information](#)

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

Member Quality of Care (“QOC”)/Quality of Service (“QOS”) Investigations

[Overview](#)

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

Quality of care grievances and PQIs are processed by clinical associates. Medical records and a response from the Provider and or Facility are requested. If the clinical associate determines the case is a non-issue with no identifiable quality issue, the clinical associate may assign a severity level C-0. A clinical associate may also assign a severity level rating of C-1 if the case meets the criteria for a known complication. A clinical associate may issue a C-3 rating for a Provider’s or Facility’s failure to submit requested information. Otherwise, the clinical associate will send a case summary to the Medical Director for review (i.e., First Level Peer Review). The case summary will include a list of previous severity levels assigned to the involved Provider and/or Facility on a rolling 12-month basis. If there are no previous severity levels, this will be documented. The Medical Director will select a specialty matched reviewer to evaluate the case, as appropriate. Upon completion of the review, the Medical Director makes a final determination and assigns a severity level for tracking and trending purposes. Upon completion of First Level Peer Review, if the case is a 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. In addition, the clinical associate will send a letter to the Provider and/or Facility explaining the outcome of the review and the severity level assigned.

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

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

[Corrective Action Plans \(“CAP”\)](#)

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

[Reporting](#)

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

[Severity Levels for Quality Assurance](#)

Quality of Care		
Level	Points Assigned	Description
C-0	0	No quality of care issue found to exist.
C-1	0	Predictable/unpredictable occurrence within the standard of care. Recognized medical or surgical complication that may occur in the absence of negligence and without a QOC concern.
C-2	5	Communication, administrative, or documentation issue that adversely affected the care rendered.
C-3	5	Failure of a practitioner/provider to respond to a member grievance regarding a clinical issue despite two requests per internal guidelines.

C-4	10	Mild deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be mildly beneath the standard of care.
C-5	15	Moderate deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be moderately beneath the standard of care.
C-6	25	Significant deviation from the standard of care. A clinical issue that would be judged by a prudent professional to be significantly beneath the standard of care.

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

[Trend Threshold for Analysis](#)

Quality of Care and Service Trend Parameters

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

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

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

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

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

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

Product Summary

[Anthem Blue Cross and Blue Shield Products](#)

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

[Federal Employee Health Benefit Program Plans](#)

Please refer to the Benefits and Services on the Federal Employee Health Benefit Program (FEHBP) Web Site at

www.fepblue.org for additional information.

[Other Products](#)

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

Medicare Advantage

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

Medicare Advantage Provider Manuals are available on the Medicare Eligible website referenced above. [Medicare Advantage HMO and PPO Provider Guidebook](#)

Federal Employee Health Benefits Program

[FEHBP Requirements](#)

Providers and Facilities acknowledge and understand that Anthem participates in the Federal Employees Health Benefits Program ("FEHBP"). The Anthem FEHBP encompasses the Blue Cross and Blue Shield Association Service Benefit Plan, otherwise known as "Federal Employee Program[®]" or "FEP[®]", - the health insurance Plan for federal employees. Providers and Facilities further understand and acknowledge that the FEHBP is a federal government program and the requirements of the program are subject to change at the sole direction and discretion of the United States Office of Personnel Management.

Providers and Facilities agree to abide by the rules, regulations, and other requirements of the FEHBP as they exist and as they may be amended or changed from time to time, with or without prior notice. Providers and Facilities further agree that, in the event of a conflict between the Provider or Facility agreement or this Provider Manual and the rules, regulations, or other requirements of the FEHBP, the terms of the rules, regulations, and other requirements of the FEHBP shall control.

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

[Submission of Claims under the Federal Employees Health Benefits Program](#)

All Claims under the FEHBP must be submitted to Plan for payment within one hundred eighty (180) calendar days from the date of discharge or from the date of the primary payer's explanation of benefits. Providers and Facilities agree to provide to Plan, at no cost to Anthem or 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 one hundred eighty (180) calendar day period will not begin to run until Provider or Facility receives notification of primary payer's responsibility. Plan is not obligated to pay Claims received after this one hundred eighty (180) calendar day period. Except where the Member did not provide Plan identification, Provider and 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](#)

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

[Coordination of Benefits for FEHBP](#)

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

[FEHBP Waiver Requirements](#)

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

[FEHBP Member Reconsiderations and Appeals](#)

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

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

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

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

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

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

Providers or Facilities may not submit appeals to the OPM. Only the Member or contract holder may do so, as outlined in the Member's benefit brochure.

[FEHBP Formal Provider and Facility Appeals](#)

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

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

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

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

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

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

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

[FEHBP Inpatient Skilled Nursing Facility Care](#)

- Effective January 1, 2018 benefits are available for up to 30 days of inpatient skilled nursing facility ("SNF") care per benefit year for Standard Option Members who are not enrolled in Medicare Part A.
- Hospitals and Plan staff must be proactive in identifying Members for whom a SNF stay is an appropriate level of care in the continuum toward transition home.
- The Member must be enrolled in case management ("CM") and the signed consent for CM must be received by the case manager prior to precertification approval of the SNF admission. This will require that the hospital discharge planning staff collaborate with the Plan case manager, and in some cases, will necessitate the hospital case manager/discharge planner's assistance in delivering the consent to the Member and having it returned to the Plan after the Member/proxy signs the document.
- The transferring facility must submit a detailed description of the Member's clinical status and the proposed treatment plan for the Plan's review of the proposed admission.
- Once the Member is admitted and subsequently within the timeframes established by the Plan, the SNF representative must provide specific information regarding the Member's status, progress towards goals, changes to the treatment plan and/or discharge plan (if applicable) and documentation of any obstacles preventing the Member from achieving the goals.
- The attending physician in the SNF must write admission orders and review the preliminary treatment plan within 24 hours of the Member's admission. Members admitting on a ventilator must be seen by a pulmonologist within 12 hours of admission and respiratory therapy be available in the facility 24 hours/day.
- Members admitted for rehabilitation must receive an evaluation by a physical therapist and a physical therapy treatment plan must be in place within 16 hours of admission. Members admitted primarily for rehabilitation must receive at least 2 hours of physical therapy and occupational therapy combined at least 5 days per week (logs must be provided to the Plan to document therapy time).

A [Provider Toolkit](#) is available to help hospital and SNF personnel understand and meet the benefit requirements.

BlueCard Program Overview

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

For more information about the BlueCard Program, Providers and Facilities can access the BlueCard Provider Manual, online at anthem.com, select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. Select the Communications menu>General Information > [BlueCard Provider Manual](#)

Health Insurance Marketplace (exchanges)

[Health Insurance Marketplace](#)

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

Critical updates about Anthem's ACA compliant health plans and the networks supporting these plans can be found on the Health Insurance Exchange information dedicated web page. Go [anthem.com](#), select **Providers** under Partner Login. On the **Provider landing page**, choose **Find Resources for Your State** and pick your state from the list. Select Communications and [Health Insurance Exchange Information](#). In addition to posting information to our website, articles are published in our provider newsletter, *Network Update*, and sent via our email service, Network eUPDATE, to communicate information about ACA compliant health plans. To sign up for Network eUPDATE's go to <https://messageinsite.com/networkupdate>.

Additional information and current communications about Health Insurance Exchanges can be found from the provider homepage at [anthem.com](#).

Important reminders

Providers and Facilities are able to confirm their participation status by using the Find a Doctor tool. Please see the Online Provider Directories and Demographic Data Integrity section for more details.

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 a Member's Health Benefit Plan and in accordance with this Policy.

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

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

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

Definition:

The following definitions shall apply to this Audit section only:

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

- Appeal means Anthem's or its designee's review of the disputed portions of the Audit Report, conducted at the written request of a Provider or Facility and pursuant to this Policy.
- Appeal Response means Anthem's or its designee's written response to the Appeal after reviewing all Supporting Documentation provided by Provider or Facility.
- Audit means a qualitative or quantitative review of Health Services or documents relating to such Health Services rendered by Provider or Facility, and conducted for the purpose of determining whether such Health Services have been appropriately reimbursed under the terms of the Agreement.
- Audit Report and Notice of Overpayment ("Audit Report") means a document that constitutes notice to the Provider or Facility that Anthem or its designee believes an overpayment has been made by Anthem and identified as the result of an Audit. The Audit Report shall contain administrative data relating to the Audit, including the amount of overpayment and findings of the Audit, that constitute the basis for Anthem's or its designee's belief that the overpayment exists. Unless otherwise stated in the Agreement between the Provider or Facility and Anthem, Audit Reports shall be sent to Provider or Facility in accordance with the Notice section of the Agreement.
- Business Associate or designee means a third party designated by Anthem to perform an Audit or any related Audit function on behalf of Anthem pursuant to a written agreement with Anthem.
- Provider or Facility means an entity with which Anthem has a written Agreement.
- Provider Manual means the proprietary Anthem document available to the Provider and Facility, which outlines certain Anthem Policies.
- Recoupment means the recovery of an amount paid to Provider or Facility which Anthem has determined constitutes an overpayment not supported by an Agreement between the Provider or Facility and Anthem. A Recoupment is generally performed against a separate payment Anthem makes to the Provider or Facility which is unrelated to the services which were the subject of the overpayment, unless an Agreement expressly states otherwise or is prohibited by law. Recoupments shall be conducted in accordance with applicable laws and regulations.
- Supporting Documentation means the written material contained in a 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.

Policy

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

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)
2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)
3. Claims with unlisted or miscellaneous codes
4. Claims for services requiring clinical review
5. Claims for services found to possibly conflict with covered benefits for Members after validity review of the Member's medical records
6. Claims for services found to possibly conflict with Medical Necessity of covered benefits for Members
7. Claims requesting an extension of benefits
8. Claims being reviewed for potential fraud, abuse or demonstrated patterns of billing/coding inconsistent with peer benchmarks
9. Claims for services that require an invoice
10. Claims for services that require an itemized bill
11. Claims for beneficiaries where other health insurance (OHI) is indicated with the Claim submission
12. Claims requiring documentation of the receipt of an informed consent form

13. Claims requiring a certificate of Medical Necessity
14. Appealed Claims where supporting documentation may be necessary for determination of payment
15. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation
16. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

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

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

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

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

Procedure:

1. Review of Documents. Anthem or its designee will request in writing or verbally, final and complete itemized bills and/or complete medical records for all Claims under review. The Provider or Facility will supply the requested documentation in the format requested by Anthem or its designee within the time frame outlined above.
2. Scheduling of Audit. After review of the documents submitted, if Anthem or its designee determines an Audit is required, Anthem or its designee will call the Provider or Facility to request a mutually satisfactory time for Anthem or its designee to conduct an Audit; however, the Audit must occur within forty-five (45) calendar days of the request.
3. Rescheduling of Audit. Should Provider or Facility desire to reschedule an Audit, Provider or Facility must submit its request with a suggested new date to Anthem or its designee in writing at least seven (7) calendar days in advance of the day of the Audit. Provider's or Facility's new date for the Audit must occur within thirty (30) calendar days of the date of the original Audit. Provider or Facility may be responsible for cancellation fees incurred by Anthem or its designee due to Provider's or Facility's rescheduling.
4. Under-billed and Late-billed Claims. During the scheduling of the Audit, Provider or Facility may identify Claims for which Provider or Facility under-billed or failed to bill for review by Anthem during the Audit. Under-billed or late-billed Claims not identified by Provider or Facility before the Audit commences will not be evaluated in the Audit. These Claims may, however, be submitted (or resubmitted for under-billed Claims) to Anthem for adjudication.
5. Scheduling Conflicts. Should the Provider or Facility fail to work with Anthem, or its designee in scheduling or rescheduling the Audit, Anthem or its designee retains the right to conduct the Audit with a seventy-two (72) hour advance written notice, which Anthem or its designee may invoke at any time. While Anthem or its designee prefers to work with the Provider or Facility in finding a mutually convenient time, there may be instances when Anthem or its designee must respond quickly to requests by regulators or its

clients. In those circumstances, Anthem or its designee will send a notice to the Provider or Facility to schedule an Audit within the seventy-two (72) hour timeframe.

6. On-Site and Desk Audits. Anthem or its designee may conduct Audits from its offices or on-site at the Provider's or Facility's location. If Anthem or its designee conducts an Audit at a Provider's or Facility's location, Provider or Facility will make available suitable work space for Anthem's or its designee's on-site Audit activities. During the Audit, Anthem or its designee will have complete access to the applicable health records including ancillary department records and/or invoice detail without producing a signed Member authorization. When conducting credit balance reviews, Provider or Facility will give Anthem or its designee a complete list of credit balances for primary, secondary and tertiary coverage, when applicable. In addition, Anthem or its designee will have access to Provider's or Facility's patient accounting system to review payment history, notes, Explanation of Benefits and insurance information to determine validity of credit balances. If the Provider or Facility refuses to allow Anthem or its designee access to the items requested to complete the Audit, Anthem or its designee may opt to complete the Audit based on the information available. All Audits (to include medical chart audits and diagnosis related group reviews) shall be conducted free of charge despite any Provider or Facility policy to the contrary.
7. Completion of Audit. Upon completion of the Audit, Anthem or its designee will generate and give to Provider or Facility a final Audit Report. This Audit Report may be provided on the day the Audit is completed or it may be generated after further research is performed. If further research is needed, the final Audit Report will be generated at any time after the completion of the Audit, but generally within ninety (90) days. Occasionally, the final audit report will be generated at the conclusion of the exit interview which is performed on the last day of the Audit. During the exit interview, Anthem or its designee will discuss with Provider or Facility its Audit findings found in the final Audit Report. This Audit Report may list items such as charges unsupported by adequate documentation, under-billed items, late billed items and charges requiring additional supporting documentation. If the Provider or Facility agrees with the Audit findings, and has no further information to provide to Anthem or its designee, then Provider or Facility may sign the final Audit Report acknowledging agreement with the findings. At that point, Provider or Facility has thirty (30) calendar days to reimburse Anthem the amount indicated in the final Audit Report. Should the Provider or Facility disagree with the final Audit Report generated during the exit interview, then Provider or Facility may either supply the requested documentation or Appeal the Audit findings.
8. Provider or Facility Appeals. See Audit Appeal Policy.
9. No Appeal. If the Provider or Facility does not formally Appeal the findings in the final Audit Report **and** submit supporting documentation within the (thirty) 30 calendar day timeframe, the initial determination will stand and Anthem or its designee will process adjustments to recover the amount identified in the final Audit Report.

Documents Reviewed During an Audit:

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

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

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

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

The auditor will verify that the billing is free of keystroke errors. Auditors may also review the Member'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 Member's Claim. Other appropriate documentation for Health Services provided to the Member may exist within the Provider's or Facility's ancillary departments in

the form of department treatment logs, daily charge records, individual service/order tickets, and other documents. Anthem or its designee may have to review a number of documents in addition to the health record to determine if documentation exists to support the Charges on the Member's Claim. The Provider or Facility should make these records available for review and must ensure that Policies exist to specify appropriate documentation for health records and ancillary department records and/or logs.

[Audit Appeal Policy](#)

Purpose:

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

Procedure:

1. Unless otherwise expressly set forth in an Agreement, Provider or Facility shall have the right to Appeal the Audit Report. An Appeal of the Audit Report must be in writing and received by Anthem or its designee within thirty (30) calendar days of the date of the Audit Report unless State Statute expressly indicates otherwise. The request for Appeal must specifically detail the findings from the Audit Report that Provider or Facility disputes, as well as the basis for the Provider's or Facility's belief that such finding(s) are not accurate. All findings disputed by the Provider or Facility in the Appeal must be accompanied by relevant Supporting Documentation. Retraction will begin at the expiration of the thirty (30) calendar days unless expressly prohibited by contractual obligations or State Statute.
2. A Provider's or Facility's written request for an extension to submit an Appeal complete with Supporting Documentation or payment will be reviewed by Anthem or its designee on a case-by-case basis. If the Provider or Facility chooses to request an Appeal extension, the request should be submitted in writing within thirty (30) calendar days of receipt of the Audit Report. One Appeal extension may be granted during the Appeal process at Anthem's or its designee's sole discretion, for up to thirty (30) calendar days from the date the Appeal would otherwise have been due. Any extension of the Appeal timeframes contained in this Policy shall be expressly conditioned upon the Provider's or Facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in an Agreement which limits the timeframe by which a Recoupment must be completed. It is recognized that governmental regulators are not obligated to the waiver.
3. Upon receipt of a timely Appeal, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall issue an Appeal Response to the Provider or Facility. Anthem's or its designee's response shall address each matter contained in the Provider's or Facility's Appeal. If appropriate, Anthem's or its designee's Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report. Anthem's or its designee's response shall be sent via certified mail to the Provider or Facility within thirty (30) calendar days of the date Anthem or its designee received the Provider's or Facility's Appeal and Supporting Documentation. Revisions to the Audit data will be included in this mailing if applicable.
4. The Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's Appeal Response to respond with additional documentation or, if appropriate in the State, a remittance check to Anthem or its designee. If no Provider or Facility response or remittance check (if applicable) is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall begin recoupment of the amount contained in Anthem's or its designee's response, and a confirming recoupment notification will be sent to the Provider or Facility.
5. Upon receipt of a timely Provider or Facility response, complete with Supporting Documentation as required under this Policy, Anthem or its designee shall formulate a final Appeal Response. Anthem's or its designee's final Appeal Response shall address each matter contained in the Provider's or Facility's response. If appropriate, Anthem's or its designee's final Appeal Response will indicate what adjustments, if any, shall be made to the overpayment amounts outlined in the Audit Report or final Appeal Response. Anthem's or its designee's final Appeal Response shall be sent via certified mail to the Provider or Facility within fifteen (15) calendar days of the date Anthem or its designee received the Provider or Facility response and Supporting Documentation. Revisions to the Audit Report will be included in this mailing if applicable.
6. If applicable in the state, the Provider or Facility shall have fifteen (15) calendar days from the date of Anthem's or its designee's final Appeal Response to send a remittance check to Anthem or its designee. If no remittance check is received within the fifteen (15) calendar day timeframe, Anthem or its designee shall recoup the amount contained in Anthem's or its designee's final Appeal Response, and a confirming Recoupment notification will be sent to the Provider or Facility.

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

Fraud, Waste and Abuse Detection

We are committed to protecting the integrity of our health care programs and the effectiveness of our operations by preventing, detecting and investigating fraud, waste and abuse (FWA). Combating FWA begins with knowledge and awareness.

- *Fraud – intentionally falsifying information and knowing that deception will result in improper payment and/or unauthorized benefit. This includes, knowingly soliciting, receiving, and/or offering compensation to encourage or reward referrals for items or services and/or making prohibited referrals for certain designated health services.*
- *Waste – includes overusing services, or other practices that, directly or indirectly, result in unnecessary costs. Waste is generally not considered to be driven by intentional actions, but rather occurs when resources are misused.*
- *Abuse – when health care providers or suppliers do not follow appropriate medical billing practices or medical practices resulting in unnecessary or excessive costs, incorrect payment, misuse of codes, or services that are not medically necessary.*

Investigation Process

The Special Investigations Unit (“SIU”) investigates suspected incidents of FWA for all types of services. We may take corrective action with a Provider or Facility, which may include, but is not limited to:

- *Written warning and/or education:* We send letters to the Provider or Facility advising the Provider or Facility of the issues and the need for improvement. Letters may include education or requests for repayment, or may advise of further action.
- *Medical record review:* We review medical records to investigate allegations or validate the appropriateness of Claims submissions.
- *Special Claims review:* A certified professional coder or investigator evaluates Claims and places payment or system edits in Anthem's Claims processing system. This type of review prevents automatic Claims payments in specific situations.
- *Recoveries:* We recover overpayments directly from the Provider or Facility. Failure of the Provider or Facility to return the overpayment may result in reduced payment for future Claims, termination from our network, or legal action.

Acting on Investigative Findings

In addition to the previously mentioned actions, we may refer suspected criminal activity committed by a Member, Provider or Facility to the appropriate regulatory and/or law enforcement agencies.

Pre-Payment Review

One method Anthem uses to detect FWA is through pre-payment Claim review. Through a variety of means, certain Providers or Facilities, or certain Claims submitted by Providers or Facilities, may come to Anthem's attention for behavior that might be identified as unusual, or for coding or billing or Claims activity that indicates the Provider or Facility is an outlier compared to his/her/its peers. .

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

If, despite the Provider's or Facility's response, Anthem continues to believe the Provider's or Facility's actions involve FWA, or some other inappropriate activity, the Provider or Facility may be placed on pre-payment review. If that occurs, the Provider or Facility will receive written notice of being placed on pre-payment review. This means that the Provider or Facility will be required to submit medical records with each Claim so Anthem can review the appropriateness of the services billed. Failure to submit medical records to Anthem in accordance with this requirement will result in a rejection of the Claim under review. The Provider or Facility will be given the opportunity to request a discussion of his/her/its pre-payment review status.

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

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

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

[Recoupment/Offset/Adjustment for Overpayments](#)

Anthem shall be entitled to offset and recoup an amount equal to any overpayments or improper payments made by Anthem to Provider or Facility against any payments due and payable by Anthem to Provider or Facility with respect to any Health Benefit Plan under this Agreement. Provider or Facility shall voluntarily refund all duplicate or erroneous Claim payments regardless of the cause, including, but not limited to, payments for Claims where the Claim was miscoded, non-compliant with industry standards, or otherwise billed in error, whether or not the billing error was fraudulent, abusive or wasteful. Upon determination by Anthem that any recoupment, improper payment, or overpayment is due from Provider or Facility, Provider or Facility must refund the amount to Anthem within thirty (30) calendar days of the date of the overpayment refund notice from Anthem to the Provider or Facility. If such reimbursement is not received by Anthem within the thirty (30) calendar days following the date of such notice letter, Anthem shall be entitled to offset such overpayment against other Claims payments due and payable by Anthem to Provider or Facility under any Health Benefit Plan in accordance with Regulatory Requirements. In such event, Provider or Facility agrees that all future Claim payments applied to satisfy Provider's or Facility's repayment obligation shall be deemed to have been paid in full for all purposes. Should Provider or Facility disagree with any determination by Plan that Provider or Facility has received an overpayment, Provider or Facility shall have the right to appeal such determination under Anthem's procedures set forth in the provider manual, and such appeal shall not suspend Anthem's right to recoup the overpayment amount during the appeal process unless prohibited by law. Anthem reserves the right to employ a third party collection agency in the event of non-payment.

Pharmacy Home Program

The availability and access to opioid medications used for the treatment of acute and chronic health conditions is at an all-time high. This access to healthcare is helping patients live longer and healthier lives. However, it can also lead to safety concerns when Members are on multiple controlled medications that are prescribed by multiple healthcare providers. To address this growing opioid epidemic, Anthem implemented the Pharmacy Home Program in April 2016 to allow for better administration of drug benefits through increased communication and coordination amongst prescribing physicians and pharmacies. The information in this section applies to Anthem Members with our prescription drug coverage.

The Pharmacy Home program helps reduce potential overutilization of prescription medications. If a Member is believed to be at an increased safety risk due to the overutilization of multiple medications, providers and/or pharmacies; and meets enrollment criteria they may be included in this program. Anthem is able to increase communication and coordination amongst prescribing physicians for Members that have been identified and restricted to a single pharmacy. The pharmacy is selected by the Member and/or is assigned based on the retrospective Drug Utilization Review ("DUR") of their prescription claims history.

The program is designed to limit a qualifying Member to the use of one specific participating pharmacy for a period of no less than 12 consecutive months. This assigned pharmacy, or Pharmacy Home, will fill all of the Member's prescribed medications throughout the term of their enrollment in this program.

The Pharmacy Home program includes:

- Reimbursement of claims when filled at the Member's Pharmacy Home. All pharmacy claims¹ are denied if filled at any pharmacy other than the Member's assigned Pharmacy Home².
- Temporary overrides for urgent prescriptions.
- Access to Mail Order and Specialty pharmacies, in addition to the Pharmacy Home.

Criteria

A Member whose prescription claims history shows they meet the below inclusion criteria may be enrolled in the Pharmacy Home program if³:

- The Member received five or more controlled substance prescriptions (government-regulated drugs) in a 90-day period.
- The Member received controlled substance prescriptions from three or more prescribers in a 90-day period.
- The Member visited three or more pharmacies to fill controlled substance prescriptions in a 90-day period.

Communications to Members meeting criteria

Members who meet criteria are sent a notification at least 60 days prior to potential inclusion in the program. After a 60-day monitoring period, if the candidate continues to meet the program criteria during that timeframe, he/she is contacted in writing of the decision to place him/her into the Pharmacy Home program and will be given 30 additional days to select a Pharmacy Home and/or to file an appeal of the decision. In the event the Member does not select a Pharmacy Home within the allotted timeframe, one will be chosen for the Member based on their pharmacy claims data on the 31st day. Anthem will ensure both the Member and their Provider will be notified of their new pharmacy home in writing. Once they have chosen a home pharmacy, a request to change pharmacies will be considered only for good cause situations.

Anthem is more committed than ever to equipping Providers with the tools and support necessary to help curb these trends and save more lives than are lost. If you have any questions or comments regarding enrollment, please contact the Member Services number located on the back of the Member's ID.

¹ Both controlled and non-controlled medications must be filled at the designated home pharmacy.

² A Member may change the designated pharmacy only if the request meets good cause criteria.

³ Exemption of members with a diagnosis of Cancer, HIV, Multiple Sclerosis, Sickle-cell Anemia or those that are in Hospice Care. (Note: Exemptions are determined by both pharmacy claim history and medical diagnosis.)

Important Links

BlueCard

[http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/oh/f5/s1/t0/pw_035482.htm&state=mo&rootLevel=4&label=The Blue Card Program](http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/oh/f5/s1/t0/pw_035482.htm&state=mo&rootLevel=4&label=The+Blue+Card+Program)

Centers of Medical Excellence/Blue Distinction

[http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/noapplication/f2/s3/t0/pw_ad094863.htm&state=mo&rootLevel=1&label=Centers of Medical Excellence](http://www.anthem.com/wps/portal/ahpprovider?content_path=provider/noapplication/f2/s3/t0/pw_ad094863.htm&state=mo&rootLevel=1&label=Centers+of+Medical+Excellence)

Coordination of Benefits Questionnaire

http://www.anthem.com/provider/noapplication/f1/s0/t0/pw_ad095423.pdf?refer=ahpprovider&state=mo

Electronic Data Interchange (EDI)

www.anthem.com/edi select "Missouri" [Access Electronic Data Interchange \(EDI\) Services](#)

Federal Employee Health Benefit Program®

<http://www.fepblue.org/>

Important Phone Numbers

https://www11.anthem.com/provider/mo/f5/s2/t0/pw_ad081365.pdf?refer=ahpprovider&state=mo

Interactive Care Reviewer (ICR) Webinar

https://antheminc.webex.com/mw3000/mywebex/default.do?nomenu=true&siteurl=antheminc&service=6&rnd=0.40124407969906073&main_url=https%3A%2F%2Fantheminc.webex.com%2Fec3000%2Feventcenter%2Fprogram%2FprogramDetail.do%3FtheAction%3Ddetail%26internalProgramTicket%3D4832534b00000002be4fe128bc1c25f9c60c5bf0f7fd2e04f38249e6fcb53077c2a2f6ecf8f01b58%26siteurl%3Dantheminc%26internalProgramTicketUnList%3D4832534b00000002be4fe128bc1c25f9c60c5bf0f7fd2e04f38249e6fcb53077c2a2f6ecf8f01b58%26cProgViewID%3D754423%26PRID%3D9f3d602ce452c042e4e60b0441a0bd1c

Medicare Advantage Provider Information

<http://www.anthem.com/medicareprovider>

Missouri Autism Mandate

http://www.house.mo.gov/billtracking/bills_1010/biltxt/truly/HB1311.HTM.

Missouri Network Relations Consultants

https://www11.anthem.com/provider/mo/f5/s5/t5/pw_b138273.pdf?refer=ahpprovider&state=mo

Missouri Prompt Pay – Request for Additional Information

<http://www.house.mo.gov/billtracking/bills101/biltxt/truly/HB1498T.HTM>

Network eUPDATE Email Sign-up Form

http://www.anthem.com/forms/central/network_rapid_updates.html

Provider Adjustment Request Form

http://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f4/s1/t0/pw_e171361.htm&state=mo&rootLevel=3

Provider Maintenance Form

<https://central.provider.anthem.com/mwpmf/PMFControllerServlet>

Quality

[https://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f2/s3/t0/pw_e199031.htm&label=Quality Improvement and Standards&rootLevel=1&state=mo](https://www.anthem.com/wps/portal/ahpprovider?content_path=shared/noapplication/f2/s3/t0/pw_e199031.htm&label=Quality+Improvement+and+Standards&rootLevel=1&state=mo)

Taxonomy Codes

www.wpc-edi.com/taxonomy