Medicare Advantage Products:

Anthem Senior Advantage

Anthem Medicare Preferred

Blue Medicare Access

Medicare Advantage Supplement to the Anthem Network Reference Guide

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Medicare Overview

Medicare Program

The Centers for Medicare & Medicaid Services (CMS) administers Medicare, the nation's largest health insurance program, which covers nearly 40 million Americans.

Medicare is a Health Insurance Program for people 65 years of age and older, some disabled people under 65 years of age, and people with End-Stage Renal Disease (permanent kidney failure treated with dialysis or a transplant). Original Medicare is divided into two parts: Hospital Insurance (Part A) and Medical Insurance (Part B). Part A helps pay for care in a hospital, skilled nursing facility, home health care, and hospice care. Part B helps pay doctor bills and for outpatient hospital care and other medical services not covered by Part A.

Part A

Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers. There is no monthly premium for Part A if the Medicare eligible or spouse has worked at least 10 years in a Medicare-covered employment, is age 65, and a citizen or permanent resident of the United States. Certain younger disabled persons and kidney dialysis and transplant patients also qualify for premium free Part A.

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a hospital or a skilled nursing facility after a hospital stay. Part A also pays for home health and hospice care, and 80 percent of the approved cost for wheelchairs, hospital beds and other durable medical equipment (DME) supplied under the home health benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when given by a hospital or skilled nursing facility during a covered stay.

Part B

Medicare Part B pays for many medical services and supplies, but the most important coverage is for the doctor's bills. Medically necessary services of a doctor are covered no matter where received — at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. The Medicare beneficiary pays a monthly premium for Part B coverage. The amount of premium is set annually by the Centers for Medicare and Medicaid Services. Part B also covers:

- outpatient hospital services
- X-rays and laboratory tests
- certain ambulance services
- durable medical equipment
- services of certain specially qualified practitioners who are not physicians
- physical and occupational therapy
- speech/language pathology services
- partial hospitalization for mental health care
- mammograms and Pap smears
- home health care if a beneficiary does not have Part A

Medigap

Medigap coverage is specifically designed to supplement Medicare's benefits and is regulated by federal and state law. It must be clearly defined as Medicare supplement coverage and it must provide specific benefits that help fill the gaps in Medicare coverage.

Standard Medigap Plans

To make it easier for all consumers to comparison shop for Medigap coverage, states, U.S. territories and the District of Columbia limit the number of different Medigap policies that can be sold in any of those jurisdictions to no more than 10 standard Medigap plans.

Medigap policies pay most, if not all, Medicare co-insurance amounts and may provide coverage for Medicare's deductibles. The policies range from offering co-insurance amounts at lower premiums to offering other non-Medicare-covered services at higher premiums. Coverage is also provided by some plans for health care provider charges in excess of Medicare's approved amount and for some care in the home.

Medicare Advantage Plans

The Balanced Budget Act of 1997 (BBA) established Medicare Part C also referred to as Medicare Advantage. Prior to Jan. 1, 1999, Medicare HMO's existed as Medicare Risk or Medicare Cost plans. The Balanced Budget Act of 1997 was intended to increase the range of alternatives to the traditional fee for service program for Medicare beneficiaries. The options included health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

Medicare HMO

Anthem Senior Advantage (ASA) contracts with a network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. ASA members must select a primary care physician from those that are part of the plan's network. The primary care physician (PCP) is responsible for managing the member's medical care, including admissions to a hospital and referrals to specialists.

Medicare HMOs have "lock-in" requirements. This means that in order to access benefits, a member is locked into receiving all covered care from doctors, hospitals and other health care providers who are contracted with the plan. In most cases, if a member goes outside the plan for services, neither the plan nor original Medicare will pay. The member will be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which a member may receive anywhere in the world; for urgently needed care, which you may receive while temporarily away from the plan's service area; for out-of-area-renal dialysis services; and if the service is prior authorized by the plan. Urgent care is also covered inside the service area if the Plan's delivery system is temporarily unavailable or inaccessible.

An MA organization must provide coverage and payment for all services that are covered under Part A (if entitled) and Part B of Medicare.

Medicare Local PPO

Anthem Medicare Preferred (AMP) is a Medicare Advantage Local Preferred Provider Organization (PPO). A Local PPO is a managed care plan in which you pay less out-of-pocket costs when you use providers who are part of the Anthem Medicare Preferred Network. Local PPO's are available in select counties within a state. CMS allows the Medicare Advantage plan to select the counties that they want to participate in. It is not an insurance policy that pays your Medicare deductible and coinsurance charges. Instead, Anthem has a contract with the federal government that allows Anthem to administer all Medicare benefits. AMP members are not required to select a Primary Care Physician or obtain a referral for specialty care. Members are encouraged to coordinate their care through a family physician.

Medicare Regional PPO

Blue Medicare Access is a Regional Preferred Provider Organization. CMS requires the plan to offer a Regional PPO in all counties within a state. A Regional PPO is also a managed care plan in which you pay less out-of-pocket costs when you use providers who are part of the Blue Medicare Access Network. It is not an insurance policy that pays your Medicare deductible and coinsurance charges. Instead, Anthem has a contract with the federal government that allows Anthem to administer all Medicare benefits. Blue Medicare Access members are not required to select a Primary Care Physician or obtain a referral for specialty care. Members are encouraged to coordinate their care through a family physician.

Managed Care Plan Enrollment

Most Medicare beneficiaries are eligible for enrollment in a managed care plan. To enroll, an individual must:

- have Medicare Parts A & B and continue paying Part B premiums.
- live in the plan's service area.
- not have permanent kidney failure at the time of enrollment unless they are currently enrolled in the Plan's commercial product.

The plan must enroll Medicare beneficiaries, including younger disabled Medicare beneficiaries, in the order of application, without health screening. Medicare Advantage plans are required to have an open enrollment period during November each year.

Provider Participation in Anthem's MA Plans

Participation Procedures for Physicians and Physician Group(s)

Anthem's MA plans must provide for the participation of individual health care professionals through reasonable procedures that include:

(a) written notice of rules of participation,

(b) written notice of material changes in participation rules before they become effective,

(c) written notice of adverse participation changes, and

(d) process for appealing adverse physician participation decisions.

(These requirements also apply to physicians that are part of a subcontracted network.)

Provider Selection and Credentialing

Anthem's MA plans have written policies and procedures for the selection and evaluation of providers. There is a documented process with respect to providers and suppliers who have signed contracts or participation agreements.

For providers (other than physicians and other health care professionals) federal regulations require periodic verification that a provider is:

- licensed to operate in the State, and
- reviewed and approved by an accrediting body.

For physicians and other health care professionals**,** **initial credentialing** includes:

- a written application,
- verification of licensure or certification from primary sources,
- disciplinary status,
- eligibility for payment under Medicare, and
- site visits as appropriate.

The application must be signed and dated and include an attestation by the applicant of the correctness and completeness of the application and other information submitted in support of the application.

Recredentialing must occur at least every three years. Recredentialing updates information obtained during initial credentialing and considers performance indicators such as those collected through quality assurance programs, utilization management systems, handling of appeals and grievances, enrollee satisfaction surveys, and other plan activities. The recredentialing form must include an attestation of the correctness and completeness of the new information.

There must be a process for consulting with contracting health care professionals with respect to the credentialing criteria.

Anthem's MA plan's benefits may only be provided by credentialed providers who have a provider agreement with CMS permitting them to provide services under original Medicare.

Terminating Participation with Anthem's Medicare Advantage Plans

In the event a provider wishes to terminate his/her participation in either of Anthem's Medicare Advantage networks or Anthem terminates a provider for reasons other than cause, a mandatory 60-day notification is required for the termination by either party. Please refer to your contract for specific termination requirements.

Any provider requesting termination of his/her participation should send written notification to the Anthem Network Management Department in his/her region. Upon receipt of the termination request, Anthem will send a written, CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination.

MA organizations that suspend or terminate a contract due to deficiencies in the quality of care must give notice of that action to the licensing or disciplinary bodies.

Termination of a Provider Contract with Cause

A Medicare Advantage organization that suspends or terminates an agreement under which the health care professional provides service to the Medicare Advantage enrollees must give the affected provider written notice of the following:

- reason for the action;
- standards and the profiling data used to evaluate the health care professional when applicable;
- mix of health care professionals the organization needs when applicable; and
- affected health care professional's right to appeal the action and the process and timing for requesting a hearing.

The composition of the hearing panel must ensure that the vast majority of the panel members are peers of the affected health care professional.

A Medicare Advantage organization that suspends or terminates a contract with a health care professional due to deficiencies in the quality of care must give written notice of that action to licensing, disciplinary, or other appropriate authorities.

Termination of a Provider Contract without Cause

Any provider requesting termination of his/her participation should send a written notification to the Anthem Network Management Department in his/her region. Upon receipt of the termination request, Anthem will send a written CMS-approved notification of the termination to all affected members at least 30 calendar days before the effective date of termination.

Provider Anti-discrimination Rules

Plans are prohibited from discriminating with respect to reimbursement, participation or indemnification solely on the basis of a provider's licensure or certification as long as the provider is acting within the scope of such licensure or certification. This prohibition does not preclude any of the following:

- Refusal to grant participation to health care professionals in excess of the number necessary to meet the needs of enrollees; an MA plan may choose to contract with a doctor of medicine that meets the needs of enrollees and does not need to contract with another practitioner who can provide only a discrete subset of physician services.
- Use of different reimbursement amounts for different specialties or within the same specialty.
- Implementation of measures designed to maintain quality and control costs consistent with the MA organization's responsibilities.

Confidentiality and Accuracy of Enrollee Records

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

- safeguard the privacy of any information that identifies a particular enrollee,
- maintain such records and information in a manner that is accurate and timely, and
- identify when and to whom enrollee information may be disclosed.

In addition to the obligation to safeguard the privacy of any information that identifies a particular enrollee, Anthem including its participating providers, is obligated to abide by all federal and state laws regarding confidentiality and disclosure for mental health records, medical health records, and enrollee information.

Encounter Data for Risk Adjustment Purposes

Each MA organization must submit to CMS all data necessary to characterize the context and purpose of each encounter between a Medicare enrollee and a provider, supplier, physician, or other practitioner.

Physician services must be submitted by the MA organization for all the services provided by network and non-network physicians and non-physician practitioners.

The extent of the data must account for:

- services covered under the original Medicare program,

- Medicare covered services for which Medicare is not the primary payor, and
- other additional or supplemental benefits that an MA organization may provide.

The data must account separately for each provider, supplier, physician or other health care practitioner that would be permitted to bill separately under the Medicare fee-for-service program, even if they participate jointly in the same encounter.

Data requirements must also:

- conform to the requirements for equivalent data for Medicare fee-for-service when appropriate, and to all relevant national standards; and
- be submitted electronically by the Plan to the appropriate CMS contractor

MA organizations and their providers and practitioners will be required to submit medical records for the validation of encounter data as prescribed by CMS. CMS will use the data obtained under this section to determine the risk adjustment factor that it applies to annual capitation rates and any other purposes.

(Please refer to your Anthem Medicare Advantage Participation attachment).

Data Reporting Submissions — Provider agrees to provide all information necessary to meet its data reporting and submission obligations to CMS including, but not limited to, data necessary to characterize the context and purpose of each encounter between a Medicare Advantage enrollee and the provider, and data necessary for the plan to meet its reporting obligations under 42 CFR Section 422.516.

Encounter Data — Encounter data shall include all information necessary for the plan to submit data to CMS as set forth in 42 CFR Section 422.257. If the provider fails to submit encounter data accurately, completely and truthfully, in the format described in 42 CFR Section 422.257, then this will result in denials and/or delays in payment of the provider's claims.

Accuracy of Encounter Data — Provider has contractually agreed to certify the accuracy, completeness, and truthfulness of the provider's generated encounter data that the plan is obligated to submit to CMS. No later than 30 days after the beginning of every fiscal year while the Medicare Advantage participation is in effect, the provider agrees, upon request, to give the plan a certification in writing, in a format that the plan specifies, that certifies to the accuracy, completeness, and truthfulness of the provider's encounter data submitted to the plan during the specific period.

Federal Funds

Anthem has a contract with CMS to perform activities as a Medicare Advantage organization (MA). In performing its duties as an MA, Anthem receives federal payments and, as such, Anthem agrees to comply, and must ensure that all related entities, contractors, and subcontractors paid by Anthem to fulfill Anthem's obligations under its MA contract with CMS agree to comply, with all federal laws applicable to those entities receiving federal funds. The payments you receive from Anthem under this agreement for services rendered to Anthem's Medicare Advantage covered individuals are, in whole or in part, from federal funds. Thus, you, as a recipient of said federal funds, agree to comply with the following:

- Title VI of the Civil Rights Act of 1964 as implemented by regulations at 45 CFR part 84;
- The Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91;
- The Americans with Disabilities Act;
- Rehabilitation Act of 1973;
- other laws applicable to recipients to federal funds, and
- all other applicable laws and rules.

Prompt Payment by MA Organization

Receipt of claims by non-contracted providers will be considered a "clean claim" if it contains all necessary information for the purposes of encounter data requirements and complies with the requirement for a clean claim under fee-for-service Medicare.

The MA organization is bound to adhere to the following prompt payment provisions for non-contracted providers:

- pay 95 percent of clean claims within 30 days of receipt;
- pay interest on clean claims not paid within 30 days; and
- all other claims must be approved or denied with 60 calendar days from date of receipt.

All contracted providers must include a prompt payment provision in their contract, the terms of which are developed and agreed to by the MA organization and the provider.

Claims with incomplete or inaccurate data elements will be returned with written notification of how to correct and resubmit the claim. Claims that need additional information in order to be reprocessed will be suspended and a written request for the specific information will be sent to the provider. If the requested information is not received within the specified timeframe, the claim will be closed and the provider will be notified.

The MA organization may not pay, directly or indirectly, on any basis (other than emergency or urgent services) to a physician or other practitioner who has filed with the Medicare carrier an affidavit promising to furnish Medicare-covered services to Medicare beneficiaries only through private contracts.

If you would like to review any of the sections referenced in their entirety, please access the CMS website at (**www.cms.gov/medicare**). You are encouraged to review this site periodically to obtain the most current CMS policy and procedures as released.

Utilization Management — Medicare Advantage Plans

Associates located in the local health service areas, centrally in Cincinnati as well as our delegates perform utilization management activities. Components of utilization management for Anthem Senior Advantage, Anthem Medicare Preferred, and Blue Medicare Access include:

- Application of Clinical Criteria Guidelines
- Referral Management
- Access to Care and Services
- Precertification
- Concurrent Review (telephonic and on-site)
- Denials
- Emergency Care/ Urgent Care
- Case Management
- Under and Over Utilization

Application of Clinical Criteria Guidelines

Anthem uses Medicare coverage guidelines, nationally recognized clinical guidelines, and internally developed guidelines for medical appropriateness review. Actively practicing physicians are involved in the development and adoption of the criteria. Medical necessity decision making includes assessing the needs of the individual patient and characteristics of the local delivery system.

Anthem uses the following Utilization Management criteria for their MA Plans:

- ***Medicare Coverage Directives*** are the primary criteria used in making decisions regarding ASA, AMP and BMA coverage. Medicare Advantage plans are required to provide their Medicare enrollees those services that are covered under Medicare and available to other fee-for-service Medicare beneficiaries residing in the geographic area covered by the plan. This means that coverage determinations for our members must be in accordance with CMS national coverage decisions, as well as local coverage determinations by Medicare intermediaries and carriers.
- ***Anthem Medical Policy*** is developed to assist in interpreting contract benefits. Medical policy includes technology assessment and medical requirements for coverage of selected technologies and services. These guidelines are available upon request.
- ***Milliman Version 8*** (Inpatient and Surgical Care, Case Management, Home Care, and Primary and Pharmaceutical Care) is used to determine medical necessity and appropriateness of site review, assign initial length of stay for inpatient services, and review catastrophic admissions.
- ***Anthem UM Guidelines*** are used in addition to Milliman Version 8 criteria. Anthem-developed guidelines are either topics that are not part of Milliman Version 8 criteria or are modifications of those guidelines. Guidelines are also developed for Disease Management and Preventive Services. These guidelines are available upon request.

Referral Management

For ASA, the primary care physician (PCP) serves as the coordinator of care in making needed referrals or making other arrangements to ensure access to medically necessary specialty care. The PCP oversees all of the medical care and services provided to the member, including referrals to specialists. Out-of-network referrals require plan notification and authorization.

For AMP and BMA, members are not required to select a PCP or obtain a referral for specialty care. Members are encouraged to coordinate their care through a family physician. AMP and BMA members can utilize providers both in and out of the network. Precertification is still required for some services.

CMS considers plan-directed care to be the financial responsibility of the health plan and/or its contracted network but in either case, not the responsibility of the MA member. Plan-directed care is care the member believes they were instructed to obtain, or authorized to receive and such instruction and/or authorization was provided by a health plan representative. A representative of the health plan includes plan-contracted physicians.

For services that require prior authorization, it becomes extremely important that Anthem authorization procedures are followed. If a member proceeds to receive care at the direction of his/her

primary care physician or network specialist, believing that such care was verbally or otherwise authorized by the physician, the member cannot be held financially responsible. In such cases when the referring network physician fails to follow Anthem authorization protocols, Anthem may decline to pay the claim in which case the physicians will be held financially responsible for services received by the member. Again, CMS prohibits holding the member financially responsible in these cases.

ASA members are allowed to have direct access to women's health specialists within the network for routine and preventive women's health care without a PCP referral or prior authorization. AMP & BMA members also have direct access to women's health specialists and do not need prior authorization. However, they will have less out-of-pocket expense if they select a provider in the network.

Access to Care and Services

Anthem may not deny, limit, or condition the coverage or furnishing of benefits to individuals eligible to enroll in an MA plan offered by an organization on the basis of any factor that is related to health status. This includes but is not limited to the following: medical condition, claims experience, receipt of health care, medical history, genetic information, evidence of insurability and disability, except as it relates to End Stage Renal Disease.

Anthem's MA Plans must meet the requirement to provide coverage and payment for all services that are covered under Part A and Part B of Medicare.

The Medicare Advantage organization must ensure that all covered services, including additional or supplemental services contracted for by the Medicare enrollee, are accessible under the plan. Medically necessary services must be available 24 hours a day, seven days a week.

Anthem has established performance measures to assist in developing and maintaining adequate providers and practitioners in all our Medicare Advantage networks. Performance is monitored at least annually and strategies are developed as needed to overcome deficiencies in the networks. Other pertinent sources of information for reviewing network adequacy include appeals and complaints regarding access and availability. Out-of-network referrals are approved for ASA HMO members when providers and practitioners are not available or accessible in the members' geographic locations.

There are also instances where an in-network provider is not available for members in our Local and Regional PPO's. In those instances, the provider should collaborate with our Utilization Management area to obtain authorization. In certain circumstances, the member may only be responsible for the in-network cost sharing.

Providers and suppliers must be located throughout the service area. Services are generally considered accessible if they reflect usual practice and travel patterns in the local area. Generally hospital and primary care physician services must be within 30 minutes travel time for members. This guideline does not apply if usual travel patterns in a service area for hospital and primary care services exceed 30 minutes as in some rural areas.

Anthem Medicare Advantage GeoAccess standards are:

<u>HMO and Local PPO:</u>

Primary Care Physicians

- 2 Physicians within 5 miles – Urban
- 2 Physicians within 12 miles – Suburban
- 2 Physicians within 20 miles - Rural

Obstetrics/Gynecologists

- 2 Physicians within 5 miles – Urban
- 2 Physicians within 12 miles – Suburban
- 2 Physicians within 30 miles - Rural

Key High Volume Specialties

- 2 Specialists within 30 miles – All membership i.e. Cardiology, Ophthalmology, Orthopedics
- 1 Ambulatory Service Provider within 30 miles i.e. Ambulatory Surgery Center, Radiology, Comprehensive Rehab Center
- 1 Home Health Services Provider within 30 miles

Healthcare Facilities

- 1 Hospital within 30 miles
- 1 Skilled Nursing Facility within 30 miles

Behavioral Health Care

- All Professionals – 1 within 15 miles
- 1 Psychiatrist within 30 miles
- 1 Psychologist within 30 miles
- 1 Master Level Therapist within 30 miles

- ♦ All Facilities – 1 within 30 miles

Regional PPO:

Primary Care Physicians

- ♦ 2 Physicians within 12 miles – Urban
- ♦ 2 Physicians within 30 miles – Suburban
- ♦ 2 Physicians within 45 miles - Rural

Obstetrics/Gynecologists

- ♦ 2 Physicians within 12 miles – Urban
- ♦ 2 Physicians within 30 miles – Suburban
- ♦ 2 Physicians within 45 miles - Rural

Key High Volume Specialties

- ♦ 1 Specialists within 30 miles – Urban/Suburban
  - o i.e. Cardiology, Ophthalmology, Orthopedics
- ♦ 1 Specialist within 45 miles – Rural
  - o i.e. Cardiology, Ophthalmology, Orthopedics
- ♦ 1 Ambulatory Service Provider within 30 miles – Urban /Suburban
  - o i.e. Ambulatory Surgery Center, Radiology, Comprehensive Rehab Center
- ♦ 1 Ambulatory Service Provider within 45 miles – Rural
  - o i.e. Ambulatory Surgery Center, Radiology, Comprehensive Rehab Center
- ♦ 1 Home Health Services Provider within 30 miles – Urban/Suburban
- ♦ 1 Home Health Services Provider within 45 miles - Rural

Healthcare Facilities

- ♦ 1 Hospital within 30 miles – Urban/Suburban
- ♦ 1 Hospital within 45 miles - Rural
- ♦ 1 Skilled Nursing Facility within 30 miles – Urban/Suburban
- ♦ 1 Skilled Nursing Facility within 45 miles - Rural

Behavioral Health Care

- ♦ All Professionals – 1 within 30 miles – Urban/Suburban
- ♦ All Professionals – 1 within 45 miles - Rural
- ♦ 1 Psychiatrist within 30 miles – Urban/Suburban
- ♦ 1 Psychiatrist within 45 miles – Rural
- ♦ 1 Psychologist within 30 miles – Urban/Suburban
- ♦ 1 Psychologist within 45 miles – Rural
- ♦ 1 Master Level Therapist within 30 miles – Urban/Suburban
- ♦ 1 Master Level Therapist within 45 miles - Rural
- ♦ All Facilities – 1 within 30 miles – Urban/Suburban
- ♦ All Facilities – 1 within 45 miles - Rural

Appointment access standards for primary care services are:

Emergency: immediate 24 hours a day/seven days a week access available

Urgent: within 48 hours

Symptom related: within 72 hours

Routine: within two weeks

Organizations and providers who contract with Anthem's MA network are required to establish and implement appropriate treatment plans for a member with complex and serious medical conditions. Accordingly, an established treatment plan must include an adequate number of direct access visits to relevant specialty providers. Treatment plans must be time-specific and updated by the PCP.

The Anthem medical management department will coordinate authorizations for members affected by a provider termination when they are undergoing treatment for specific conditions. Members not undergoing treatment at the time of a provider termination will be referred to their PCP for a referral to another participating provider of that like specialty.

Plans may select the providers through whom services are provided as long as:

- the plan makes services available and accessible within the service area with reasonable promptness and in a manner which assures continuity; and
- the plan provides access to appropriate providers, including credentialed specialists, for medically necessary care; and if a network provider is unavailable or inaccessible then the MA

organization must arrange for services outside of the network.

- coverage is provided for emergency services; without regard to prior authorization or whether the provider was a participating provider.
- the plan maintains and monitors a network of appropriate providers;
- the plan gives women enrollees direct access to women's health specialists within the network for women's routine and preventive health care services;
- the plan establishes written standards for timeliness of access to care and member services that meet or exceed standards established by CMS and continuously monitors to assure continuous compliance with standards;
- the plan ensures services are provided in a culturally competent manner;
- the plan ensures services are available 24 hours a day, seven days a week, when medically necessary;
- the MA organization ensures continuity of care and integration of services and makes a "best effort" attempt to conduct an initial assessment of an enrollee's health care needs within 90 days of enrollment.

**Not all contracting providers have to be located within the service area but CMS must determine that all services covered under the plan are accessible from the service area.*

Direct Access to Preventive/Routine Gynecological and Mammography Services

Women enrollees may choose direct access to a women's health specialist within the network for routine and preventive health care services provided under the plan as basic benefits. These services include annual Pap testing and mammography exams. No referrals are required for routine gynecological exams or mammography services provided by a network provider for ASA.

Please refer to the most recent Medicare Advantage provider directory for the Mammography Center and OB/GYN specialty provider listings. Our provider directories are also available on-line at www.anthem.com.

Direct Access to Influenza and Pneumococcal Immunizations with NO Cost Sharing

Anthem strongly encourages all members to receive influenza and pneumococcal immunizations. Although these services for ASA members must be obtained through network providers, no referral or copayment for the immunization is required. AMP and BMA members may obtain services from network or non-network providers and there is $0 copay for these immunizations.

Precertification

The Anthem Precertification Department is notified of all inpatient admissions, including hospital, skilled nursing facility, rehabilitation, and selected outpatient procedures. UM associates will be requesting relevant clinical information, including signs, symptoms, treatment plans, diagnostic test results and attempts at conservative treatment (when appropriate) in order to complete the precertification process.

Anthem makes a good faith effort to respond to all precertification decisions within one (1) business day of the receipt of all necessary information for urgent and non-urgent care. Anthem will make a best faith effort to notify providers of the precertification decision within one (1) business day. The notification includes information regarding the appeal process, availability of a physician to discuss the case, and the reason for the denial including the specific clinical criteria or benefits provision. Appropriately licensed and trained professionals make UM decisions according to established criteria. Non-clinical associates, under the supervision of a licensed professional, may collect non-clinical data and may approve cases that do not require clinical review. Board-certified practitioners are utilized in making decisions of medical necessity. Only physicians are able to render denials. Practitioners from appropriate specialty areas are utilized as needed for medical necessity reviews and appeals.

Please contact your local provider relations department to obtain the most current copy of the MA Precertification list.

Inpatient Acute Concurrent Review (Telephonic and On-site)

Anthem performs on-site concurrent review for Medicare Advantage members at contracted in-area hospitals. The review's purpose is to continuously improve medical care by:

- determining the need for continued stay, and
- initiating discharge planning and case management.

Local health service area (HSA) utilization management associates perform this activity. On-site reviews include both patient chart review and face-to-face interaction with the patient, family (if available), and hospital associates. This process allows the nurse to evaluate firsthand the patient's physical and mental condition and social issues surrounding the admission that cannot be represented fully in the chart or by telephone review.

Denials

Inpatient admissions and discontinuation of coverage

Administrative denials for lack of information may not be issued for Anthem Senior Advantage (ASA), Anthem Medicare Preferred (AMP) or Blue Medicare Access (BMA) members. CMS does not recognize denials due to a lack of information. Therefore, when there is not enough information to certify or deny a requested service requiring Utilization Management review, further attempts must be made to collect the missing information

Based on the application of our clinical criteria guidelines, if the admission or continued inpatient stay does not meet medical necessity criteria, it is referred to the medical director or physician consultant for medical necessity determination. Physician review decisions are made within one working day. Plan providers are also entitled to a physician to physician review.

For inpatient care, the member must receive a Detailed Notice of Discharge (CMS-10066) that details specifically what services or items are being discontinued or terminated, and what the financial liability of the member is if they receive the inpatient care being denied. This notice is given when the member's attending physician is in agreement with the plan's decision. The member's notice will also contain specific information about his/her appeal rights and the process to use to appeal this adverse determination.

Service denials

When a contracted provider is denied a request for a service for a member, federal regulations [CFR §422.568(c) and (d)] grant an MA member the right to receive a Notice of Denial of Medical Coverage (NDMC) from the MA organization regarding his/her appeal rights. Therefore, a physician or practitioner is required as a matter of routine to notify members about their right to receive such information. The notice to the member must provide, in addition to information about the right to receive detailed information, all information necessary to allow the member to contact the health plan. Anthem's Network Management department will provide the required notification language along with guidance on delivery methods acceptable to CMS.

Special Rules for Emergency and Urgently Needed Services, Post-Stabilization Care, and Ambulance Services

Anthem's MA plans are financially responsible for emergency services provided by contracted and non-contracted providers where services are immediately required because of an emergency medical condition. The Plan is also responsible for urgently needed services, post-stabilization care, and ambulance services, including ambulance services dispatched through 911 or its local equivalent, where other means of transportation would endanger the beneficiary's health.

A Medicare Advantage organization is required to cover emergency services for its MA members regardless of whether the services were pre-authorized or the organization has a contractual agreement with the provider of the services. Therefore, emergency services for members are covered without regard to prior authorization or whether services were provided in or out of the service area.

Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson, with an average knowledge of health and medicine,

could reasonably expect the absence of immediate medical attention to result in:

- serious jeopardy to the health of the individual
- serious impairment to bodily functions
- serious dysfunction of any bodily organ or part

Urgently needed services are not emergency services as defined above, but are covered services which are medically necessary and immediately required as a result of unforeseen illness, injury or condition and it was not reasonable, given the circumstances, to obtain the services through the organization. For example, urgently needed services are covered when:

- an enrollee is temporarily absent from the MA plan's service area, or
- when the enrollee is in the service area and there are extraordinary circumstances that cause the provider network to be temporarily unavailable or inaccessible.

Post-Stabilization Care is defined as covered services pertaining to an emergency medical condition provided after the member is stabilized. It is to be determined by the attending physician and under specific circumstances includes care to improve or resolve the enrollee's condition. The treating physician is responsible for determining when the member is considered stabilized for transfer or discharge. For the purposes of this requirement, post-stabilization care and maintenance care are used synonymously.

The plan's financial responsibility for post-stabilization care services includes:

- any service administered, even though not pre-approved by the plan or its representative, during the one-hour period following the request to the MA organization for pre-approval of further post-stabilization care;
- services administered to maintain, improve, or resolve the enrollee's stabilized condition if the MA organization does not respond to the request for pre-approval within one hour; or
- the MA organization's representative and the treating physician cannot reach an agreement concerning care decisions and a plan physician is not available for consultation.

The plan's financial responsibility for post-stabilization care ends when:

- a plan physician with privileges at the treating hospital assumes responsibility for the member's care,
- a plan physician assumes care through transfer,
- the MA organization's representative and the treating physician reach an agreement on the member's care, OR
- the member is discharged.

Case Management

Case Management is a collaborative process that assesses, develops, implements, coordinates, monitors, and evaluates case management plans designed to optimize members' health care benefits while empowering the members to exercise the options and access the services appropriate to meet their individual health needs, using communication and available resources to promote quality and effective outcomes.

Members who might benefit from case management are identified through a referral process. Case management referrals will be accepted from both internal and external sources.

- Internal sources include, but are not limited to, utilization management associates, customer service associates, account managers, appeals/grievance associates, sales staff, and small/large group underwriting.
- External sources include, but are not limited to, hospital staff, discharge planners, social services, physicians and other health care providers, members or their families.

In addition, case referrals can be generated prospectively from the UM system during the precertification process and retrospectively from the claims system through claims data analysis and data review activities. Case referrals may also be triggered by the results of Senior Health Questionnaire (SHQ) surveys and/or internal disease management registries, as appropriate. The Senior Health Questionnaire is a risk appraisal which evaluates health and wellness factors such as member's self perception of health, presence of chronic or serious conditions, functional limitations, prior health care utilization and availability of social support. These factors are potentially predictive of future health care needs and we make a best-effort

attempt to conduct this initial assessment of each enrollee's health benefit needs, including following up on unsuccessful attempts to contact the enrollee, within 90 days of the effective date of enrollment.

Essential functions of an Anthem Case Manager include the following:

Assessment: The case manager collects and analyzes data about actual and potential member needs. This may involve gathering data in relation to the member's medical issues, cognitive status, and functional status. After the data is analyzed there is the planning, implementing and evaluation of the case management plan.

Planning: The case manager develops a member centered case management plan. This plan is developed in conjunction with the physician and specifies goals that meet the benefit needs of the member in the best way possible. This means identifying both short and long term goals. It is essential that the case manager understand the benefits contained in the member's plan in order to formulate a case management plan.

Linking/Coordination: The case manager helps ensure continuity of care and integration of benefits across a variety of settings. Coordination is achieved through communication with the member, family and providers. The case manager may also coordinate with existing community-based programs and services. Case management will also address the multidimensional benefit needs of the individual member to help promote continuity of care.

Monitoring/Evaluation: Case management will monitor interventions, based upon benefits, to help make sure that they are in accordance with the case management plan and that they are effective. Revisions will be made as needed. If these goals are not being met then the case manager should work with the member to modify the plan for the member.

Advocacy: The case manager should incorporate the member's needs and goals in the plan. Case managers should gather input from all relevant parties to help ensure continuity of benefits so that the member will achieve optimal results. Case managers are required to help protect the privacy and confidentiality of members at all times. Case managers should also present their limitations due to potential conflicts of interest between the member and Anthem.

Skilled Nursing Facility

Anthem will coordinate Skilled Nursing Facility (SNF) benefits for our Medicare Advantage members. Inpatient SNF coverage is limited to 100 days each benefit period based on medical necessity. Anthem Senior Advantage, Anthem Medicare Preferred and Blue Medicare Access waive the Original Medicare requirement for the 3-day inpatient hospital stay for skilled coverage. Thus, the physician may directly admit a member into a SNF from various sites, including the office, home or from an observation stay.

Care in a SNF is covered if **ALL** of the following three factors are met:

- The patient requires skilled nursing services or skilled rehabilitation services, i.e., services that must be performed by or under the supervision of professional or technical personnel.
- The patient requires these skilled services on a daily basis, and
- The skilled services can be provided only on an inpatient basis in a SNF.

If any one of these three factors is not met, a stay in a SNF, even though it might include the delivery of some skilled services, may not be covered. If a stay in a SNF is not covered, Medicare Part B services may still be obtained and members will be assessed the applicable copays.

A benefit period is used to determine coverage under ASA, AMP and BMA in the same manner as Original Medicare. A benefit period starts with the first day of a Medicare covered inpatient hospital or SNF stay and ends when the member has been out of the hospital or SNF for 60 consecutive days.

Inpatient stays solely to provide custodial care are not covered under ASA, AMP, or BMA. Custodial care is defined as care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by ASA, AMP, BMA or Original Medicare unless provided in conjunction with daily skilled nursing care and/or skilled rehabilitation services.

Home Health Services

For a member to qualify for home health benefits, the member must be confined to the home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service. Under Anthem's Medicare Advantage plans, the member does not have to be bedridden to be considered confined to home. The condition of the member should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require considerable and taxing effort. If the member leaves the home, the member is still considered homebound if the absences from the home are infrequent, for periods of relatively short duration or to receive medical treatment.

Home Care includes the following services:

- Part-time or intermittent skilled nursing and home health aide services
- Physical, occupational, and speech therapy
- Medical social services
- Medical supplies
- Durable Medical Equipment
- Portable x-rays and EKGs
- Laboratory tests

Under and Over Utilization

Anthem has established measures to detect potential under and overutilization of services. Inpatient, outpatient, and ambulatory care utilization reports are monitored regularly against targets. Actions are implemented as needed. Data is monitored by product lines for the following:

- inpatient acute care
- ER visits
- high volume specialty

In addition to the above activities, underutilization is monitored through:

- reviewing new or changed contracts to identify any incentives for underutilization.
- analysis of disenrollment causes related to member concerns regarding underutilization and quality of care.
- trending appeals and grievances for trends/patterns indicating potential underutilization issues.

Anthem does not compensate, reward or incent, financially or otherwise, its employees, consultants, or agents for inappropriate restrictions of care. Utilization review decision-making for Anthem's MA plans are based solely on appropriateness of care and service and in accordance with applicable Medicare coverage criteria and guidelines.

Anthem Medicare Advantage Member Appeals and Grievances

Distinguishing Between Member Appeals and Member Grievances

There are two procedures for resolving MA member concerns: the member **appeals** process and member **grievance** process.
All member concerns are resolved through one of these mechanisms. The member's specific concern dictates which process is used. Thus, it is important for the physician to be aware of the difference between appeals and grievances.

MA member appeals

Member disputes or concerns about initial determinations are considered appeals and are resolved only through the appeals process. These are primarily concerns related to denial of services or payment for services. Examples of appeals include:

- denials of services or supplies that the member believes should be covered.
- denials of payment for emergency or out-of-area urgently needed services.
- discontinuation or reduction of services in a SNF, HHA, or CORF. (Follows Fast Track Appeal Process)

MA member grievances

All other member concerns that do not involve an initial determination are considered grievances and are addressed through the grievance process (see "MA Member Grievances" section of this manual). Examples of grievances include complaints or issues raised about:

- accessibility/timeliness of appointments
- quality of services
- Anthem MA staff
- Anthem Medicare Advantage physicians and their staff
- plan's decision not to expedite an appeal

MA Member Appeals

As Medicare Advantage enrollees, they all have the right to obtain a prompt resolution of issues raised, including complaints or grievances and concerns related to authorization, coverage, or payment of services.

Essential components of the MA Member Appeals process include:

- distinguishing between provider appeals and member appeals
- notification of appeal rights
- appeal timeframes
- filing a member appeal
- processing standard member appeals
- expedited member appeals
- types of decisions subject to expedited/ 72-hour review
- how an expedited member appeal is processed
- hospital discharge appeals and QIO review process

Distinguishing between provider appeals and MA member appeals

Anthem's Complaint and Appeal Procedures apply to provider appeals for Anthem Senior Advantage, Anthem Medicare Preferred and Blue Medicare Access. **It is critical to note that there are separate and distinct policies and processes for MA member appeals**. Thus, MA member appeals are considered separate and distinct from provider appeals.

Our members have the right to appeal any decision about our payment for, or failure to arrange or continue to arrange for, what they believe to be covered services (including non-Medicare-covered benefits. Coverage decisions that are commonly appealed include decisions with respect to:

- payment for emergency services, post-stabilization care, or urgently needed services;
- payment for any other health services furnished by a non-contracting medical provider or facility that the enrollee believes should have been arranged for, furnished, or reimbursed by Anthem;

- services the enrollee has not received, but which the enrollee feels Anthem is responsible to pay for or arrange; or,
- discontinuation of services that the enrollee believes are medically necessary covered services.

The physician should always treat an appeal as an MA member appeal rather than a provider appeal when the issue involves:

- denial of services covered by Medicare that are arranged for by Anthem's MA plans.
- reimbursement for emergency or urgently needed services.
- any other health services furnished by a provider or supplier, that the member believes are covered under Medicare and should have been arranged for or reimbursed by Anthem Medicare Advantage.
- Anthem Medicare Advantage plan refusal to arrange for services that the member believes should be arranged for by ASA, AMP or BMA.
- termination of services the member believes are medically necessary covered services or services he/she is still entitled to receive.

Provider Appeals

The physician may submit a written provider appeal concerning any case in which he or she disagrees with a Medicare Advantage payment. This essentially involves issues after a service has been rendered and a payment dispute exists between the plan and the physician.

Physician appeals follow the standard Anthem process for provider appeals (i.e., no separate policies and procedures exist for provider appeals under Anthem Medicare Advantage). Anthem participating providers may initiate provider appeals under the Midwest Provider Complaint and Appeal Procedures. The processing of a particular provider appeal may vary depending on whether or not it involves a review of medical necessity. The Provider Complaint and Appeals Procedures contain alternative steps, based on product and state, as necessary to comply with regulatory and accreditation requirements.

The Provider Complaint and Appeal Procedures are designed to permit Anthem to examine issues fully and fairly before completion of Anthem's internal review process. Special processes apply to appeals that involve utilization review decisions on clinical benefits. Anthem typically determines provider appeals within 30 calendar days (for utilization review cases) or 30 business days (for other cases) when sufficient information is received to make a decision.

Separate and distinct requirements regarding UM decisions and appeals have been established by CMS for contracting MA plans and must be followed for these members.

Notification of appeal rights

Medicare Advantage members are notified of their appeals rights and how to file an appeal through a number of ways:

- in the new member enrollment kit
- in their evidence of coverage and member handbook
- on all claim and utilization management-issued denial letters
- from Member Services if the member calls with questions

Appeal timeframes

Members have 60 days from the date of the denial of service to file either a standard or expedited appeal. The 60-day filing deadline may be extended where good cause can be shown. All standard appeal requests must be in writing. Requests for expedited appeals may be oral or in writing.

For standard appeals, we must resolve service issues within 30 calendar days and payment issues within 60 calendar days from the date the request was received.

An expedited appeal may be requested in cases when the time required to process a standard appeal could seriously jeopardize the life or health of the member or the member's ability to regain maximum function. The resolution time for all expedited appeals is 72 hours from the time the request is received.

Filing a member appeal

Any Medicare Advantage member may file an appeal for any decision made by us regarding service or payment with which he/she disagrees.

The member may also authorize someone to file an appeal on his/her behalf, including an ASA, AMP, or BMA network physician and non-network physician. We have developed a form that a member may use for authorizing someone other than a physician to represent the member. This form may be obtained from:

Anthem Medicare Advantage
Attn: Appeals (MC2-535)
4361 Irwin Simpson Road
Mason, OH 45040
Phone: (800) 467-1199 or (513) 475-1100

If a member wants to authorize a representative without using this form, the member should:

- provide his/her name, health record number, and a statement which appoints an individual as his/her representative.
- sign and date the statement.
- have the member's representative sign and date the statement.
- include this signed statement with his/her written appeal request.

The member may appoint any physician to act as his/her representative in requesting an appeal from us regarding the denial or discontinuation of medical services. A court-appointed guardian or an agent under a health care durable power of medical attorney may also file a standard or expedited appeal.

If someone files the appeal on behalf of the member, an appointment of representative letter or form must be obtained by the Anthem Medicare Advantage appeals department before a decision on the appeal can be rendered.

Members or their authorized representatives may send a letter of appeal to:

Anthem Medicare Advantage
Attn: Appeals (MC2-535)
4361 Irwin Simpson Road
Mason, OH 45040
Fax Number: (513) 336-5449

Appeals can also be filed with an office of the Social Security Administration.

Requests for expedited appeals are accepted orally or in writing. To file an expedited appeal request in writing, the member or their authorized representative may use the above address. To file an expedited appeal request orally, the member or the authorized representative may use the following numbers:

In Ohio or Kentucky:
(800) 467-1199 or (513) 475-1100

TDD number:
(888) 853-7754 or (513) 872-5614

Processing standard member appeals

If the member decides to proceed with the Medicare Standard Appeals Procedure, the following steps will occur:

- The enrollee must submit a written request for an appeal to Anthem within 60 calendar days of the date of the notice of the initial decision. The 60-day limit may be extended for good cause.
- The MA Member Appeals and Grievance Department will process the appeal and notify the enrollee in writing of the decision, using the following timeframes:
  - Standard Appeal for Service-Related Request: If the appeal is for a denied service, Anthem must notify the enrollee of the appeal decision as expeditiously as the enrollee's health requires, but no later than 30 days from receipt of the enrollee's request. Anthem may extend this timeframe by up to 14 days if the enrollee requests the extension or if additional information is needed, and the extension of time benefits the enrollee, such as the need to obtain additional medical records from non-contracting providers that could change a denial decision.
  - Standard Appeal for Payment-Related Request: If the appeal is for a denied claim, Anthem must notify the enrollee of the reconsideration determination no later than 60 days after receiving the enrollee's request for an appeal.
- Anthem's appeal decision will be made by a person(s) not involved in the initial decision. All appeals of adverse organization determinations based on "lack of medical necessity" must be made by a physician with appropriate expertise in the field of medicine appropriate for the services at issue. The enrollee or the enrollee's authorized representative may present or submit relevant facts and/or additional evidence for review either in person or in writing to Anthem.
- If Anthem decides fully in the enrollee's favor on a request for a service, the service must be provided

or authorized within 30 days of the date the enrollee's appeal request was received. If Anthem decides fully in the enrollee's favor on a request for payment, the requested payment must be made within 60 days of the date the enrollee's appeal request was received.

- If Anthem decides to uphold the original adverse decision, either in whole or in part, the entire case file will be automatically forwarded to the Center for Health Dispute Resolution (CHDR) for a new and impartial review. CHDR is CMS' independent contractor for appeal reviews involving MA plans. Anthem must send CHDR the file within 30 days of a request for services and within 60 days of a request for payment. CHDR will either uphold the MA organization's decision or issue a new decision. The enrollee will receive written notification if Anthem forwards the case to CHDR. CHDR's decision is final and binding upon Anthem.
- For cases submitted for review, CHDR will make an appeal decision and notify the enrollee in writing of their decision and the reasons for the decision. If CHDR upholds Anthem's decision, its notice will inform the enrollee of his/her right to a hearing before an administrative law judge of the Social Security Administration. If CHDR (or a higher appeal level) decides in the enrollee's favor, Anthem must pay for, provide or authorize the service as expeditiously as the enrollee's health condition requires, but no later than 60 days from the date Anthem receives the notice reversing our decision.

Expedited member appeals

For member appeals, there are distinct requirements mandated by CMS that Medicare Advantage organizations must follow.

MA-expedited determinations and appeals

MA members have the right to request and receive expedited decisions affecting the member's medical treatment in "time-sensitive" situations. This includes situations where waiting for a decision to be made within the timeframe of the standard decision-making process could seriously jeopardize the member's life or health, or the member's ability to regain maximum function. If Anthem decides, based on medical criteria, that the member's situation is time-sensitive or if any physician makes the request for the member or calls or writes in support of the member's request for an expedited review, Anthem will issue a decision as expeditiously as the member's health requires, but no later than 72 hours after receiving the request. Anthem may extend this timeframe by up to 14 days if the member requests the extension or if additional information is needed, and the extension of time benefits the member; such as when additional information is needed from the non-contracting provider that could change a denial decision.

Types of decisions subject to expedited/ 72-hour review

- **Expedited Determinations**: If the member believes he/she needs a service, or continues to need a service, and he/she believes it is a time-sensitive situation, the member or any physician (including a physician with no connection to Anthem) may request that the decision be expedited. If Anthem decides that it is a time-sensitive situation, or if any physician states that it is one, Anthem will make a decision on the member's request for a service on an expedited/72-hour basis (subject to an extension as discussed above).
- **Expedited Appeals**. If the member wants to request an appeal of a decision by Anthem to deny a service the member requested or to discontinue a service the member is receiving that the member believes is a medically necessary covered service and the member believes it is a time-sensitive situation, the member may request that the appeal be expedited. If Anthem decides that it is a time-sensitive situation, or if any physician states that it is one, Anthem will make a decision on the member's appeal on an expedited/72-hour basis. This timeframe may be extended by up to 14 days if the member requests the extension or additional information is needed, and the extension of time benefits the member.

Examples of service decisions which the member may appeal on an expedited basis, when the member believes it is a time-sensitive situation, include the following:

- if the member received a denial of a service the member requested;
- if the member believes services are being discontinued too soon, such as inpatient services.

How an expedited member appeal is processed

- To request an expedited/72-hour reconsideration, the member or the member's authorized representative may call, write, fax or visit Anthem.
- Upon receiving the member's request for an expedited appeal, Anthem will determine if the member's request meets the definition of time-sensitive.
  - If the member's request does not meet the definition, it is handled within the standard review process. The member is informed by telephone or in person whether the member's request will be processed through the expedited 72-hour reconsideration or the standard appeal process. The member is also sent a written confirmation within two working days of the phone call or personal contact. If the member disagrees with Anthem's decision to process the request within the standard timeframe, the member may file a grievance with Anthem. The written confirmation letter will include instructions on how to file a grievance. If the member's request is time-sensitive, the member will be notified of the decision as expeditiously as the member's health requires but no later than 72 hours after we receive the request.
  - An extension up to 14 calendar days is permitted for a 72-hour request for determination/appeal, if the member asks for the extension, or if more information is needed and the extension of time benefits the member.
- The member's request must be processed within 72 hours if any physician calls or writes in support of the member's request for an expedited/72-hour review, and the physician indicates that applying the standard review timeframe could seriously jeopardize the member's life or health or the member's ability to regain maximum function.
- The MA organization will make a decision on the member's request for determination/appeal and notify the member of it within 72 hours of receipt of the member's request. If Anthem decides to uphold the original adverse decision, either in whole or in part, the entire file will be forwarded by the MA organization to CHDR for review as expeditiously as the member's health requires, but no later than 24 hours after Anthem's decision. CHDR will send the member a letter with its decision within 72 hours of receipt of the member's case from Anthem.

When the member requests an expedited determination/appeal, and the member does not hear from Anthem within 72 hours of the request, the member can assume that the request has been denied. Anthem's failure to notify the member in a timely manner — within 72 hours — constitutes a denial which the member may appeal.

Hospital discharge appeals and QIO review process

Hospital discharges are subject to the expedited member appeal process. The Centers for Medicare Medicaid Services (CMS) has determined that Medicare Advantage members wishing to appeal an inpatient hospital discharge must request an immediate review from the appropriate Quality Improvement Organization (QIO) authorized by Medicare to review the hospital care provided to Medicare patients.

When an MA member does not agree with the physician's decision of discharge from the inpatient hospital setting, then the member must request an immediate review by the QIO. The member or their authorized representative, attorney, or court-appointed guardian must contact the QIO by telephone or in writing. This request must be made no later than noon of the first working day after the member receives the Notice of Discharge and Medicare Appeal Rights.

The QIO will make a decision within one full working day after it receives the member's request, the appropriate medical records, and any other information it needs to make a decision. While the member remains in the hospital, Anthem continues to be responsible for paying the costs of the stay until noon of the calendar day following the day the QIO notifies the member of its official Medicare coverage decision.

If the QIO agrees with the physicians' discharge decision, the member will be responsible for paying the cost of the hospital stay beginning at noon of the calendar day following the day the QIO provides notification of its decision. If the QIO disagrees with the physician's discharge decision, the member is not responsible for paying the cost of additional hospital days.

If an MA member misses the deadline to file for an immediate QIO review, then he/she may request an expedited appeal. In this case, the member does not have automatic financial protection during the course of the expedited appeal and may be financially liable for paying for the cost of the additional hospital days if the original decision to discharge is upheld upon appeal.

Fast Track Appeal Process

In April 2003, the Centers for Medicare and Medicaid Services (CMS) published final regulations in the Federal Register (commonly known as the Grijalva Regulation) which made improvements to the Medicare Advantage appeals and grievances procedures. It established new notice requirements and appeal procedures for MA members when coverage for provider services (specifically SNF, HHA and CORF service) is terminated or discontinued. This rule was published as a result of an agreement entered into between the parties in *Grijalva vs Shalala*, civ. 93-711 (USDC AZ.) to settle a class action lawsuit.

Effective January 2004, all Medicare Advantage beneficiaries whose services are being discontinued from a Home Health Agency (HHA), Comprehensive Outpatient Rehabilitation Facility (CORF), or are being discharged from a Skilled Nursing Facility (SNF), when services and /or admission was prior authorized are required to be notified via a two-notice process.

Notice I – The first notice to be issued: "Important Medicare Message of Non-Coverage" (NOMNC). This notice is required to be issued to all Medicare Advantage members when services are terminated or discontinued.

Notice II – The second notice to be issued: "Detailed Explanation of Non-Coverage" (DENC). This notice is only issued if the member disagrees with Notice I and requests an appeal.

MA Member Grievances

As Medicare Advantage enrollees, all members have the right to obtain a prompt resolution of issues raised, including complaints or grievances and concerns related to authorization, coverage, or payment of services.

Essential components of the member grievance process include:

- notification of grievance rights
- grievance timeframes
- who can file a grievance
- how a grievance is filed
- how a grievance is processed
- grievance outcomes

Notification of grievance rights

Members are notified of their grievance rights and how to file a grievance through a number of ways:

- in the new member enrollment kit
- in their evidence of coverage and member handbook
- from member services if the member calls with questions

Grievance timeframes

A written determination of the grievance will be sent to the member within 30 days of receiving the complaint:

Who can file a grievance

A member or authorized representative can file a grievance if he/she has an issue or concern involving quality of care, the art of caring, personnel (both plan and physician staff), and all other issues that do not involve an initial determination (payment or denial of service issues).

How a grievance is filed

As members of a Medicare Advantage plan, members have the right to file a complaint — also called a grievance — about problems they may observe or experience, including:

- complaints about the quality of services received;
- complaints regarding such issues as office waiting times, physician behavior, adequacy of facilities, or other similar concerns;
- involuntary disenrollment situations;
- disagreement with the decision to process an appeal request under the standard 30-day timeframe rather than the expedited/72-hour timeframe.

A member may call Member Services at (800) 467-1199 to initiate the grievance process.

The member service representative gathers the information from the member and forwards the grievance to the MA Appeals/Grievance Department. The member service representative may also ask the member to put any verbal complaints in writing. We have a grievance form available for members to complete or the member may write a letter on his/her own.

Written grievances should be mailed to:

Anthem Medicare Advantage
Attn: Grievances (MC2-535)
4361 Irwin Simpson Road
Mason, OH 45040
Fax Number: (513) 336-5449

How a grievance is processed

Anthem MA member service representatives will attempt the informal resolution of complaints (i.e., over the telephone), especially if such complaints result from misinformation, misunderstanding or lack of information. However, if the member's complaint cannot be resolved in this manner, the formal member grievance procedure will be followed.

Anthem MA has categorized grievances into two classifications for processing and tracking purposes. These two categories are:

- customer service grievances (complaints about Anthem MA staff and/or policies).
- provider quality grievances (complaints about the MA networks or providers).

The classification of the grievance dictates which specific internal procedure is followed.

Grievances classified as *customer service complaints* are routed to managers in the appropriate department (Member Services or Network Management) by the MA Appeals/Grievance department for review and investigation. These types of grievances are typically non-clinical in nature. A written determination will be sent to the member within the required 30-day timeframe.

Grievances classified as *provider quality grievances* are processed by Anthem's Quality Improvement department or by the delegated entity if applicable. These types of grievances are typically clinical in nature. Upon receipt of the grievance, the QI department or delegated entity will send the member an acknowledgement letter. After the investigation is complete, the QI department will send the member a final letter.

Grievance outcomes

The member is notified in writing of the outcome of the grievance investigation. The written determination includes the member's right to request a hearing before the Anthem MA Member Satisfaction Committee (MSC). This request for a hearing before the MSC must be in writing and received within 30 days of the written notification. The decision rendered by the MSC is final.

The information contained in this handbook should not be construed as treatment protocols or required practice guidelines. Diagnosis, treatment recommendations, and the provision of medical care services for Anthem members and enrollees are the responsibility of providers and practitioners. Please encourage the patient to review his/her Policy or Evidence of Coverage and Schedule of Benefits for details concerning benefits, procedures and exclusions prior to receiving treatment,
as this Handbook does not supersede the Policy or Evidence of Coverage and Schedule of Benefits. The information in this Handbook may change from time to time.

Anthem Blue Cross and Blue Shield is the trade name of: In Kentucky: Anthem Health Plans of Kentucky, Inc. In Ohio: Community Insurance Company.

Independent licensees of the Blue Cross and Blue Shield Association. ®Anthem is a registered mark. The Blue Cross and Blue Shield names and symbols are the registered marks of the Blue Cross and Blue Shield Association.